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			Registrar . Decedent's Name	(First, Middle	, Last)					2. Date of Dea Month	Day	Year	3. Time of Death 4:12 P M
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1	Examin	4	a. Facility Name (if a		give street and numi	ber)		CHESTER		31		UEEN AN	NE'S
	Funeral	5	. Social Security Nu		6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs		Year)	g. Birti	hplace (State or Foreign OTLAND
	Director		168-44-5		1 □ M 2 🛈 F	6	6 Yrs.	thio it is		102/10/	1945	130	
	and show d at	- 1	Jsual Residence of I0a. State	10b. County		10c. City	Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 No
	Aaryla Ba-f s tified	Director	MD	QUEEN	ANNE'S	CHES	TERTO				10g Cit	izen of What Co	
	th the	alD	0e. Street and Nun					10f. Zip Code 21620				TED STA	
	ath wit	Funeral	421 FEY	ROAD _	12. Was Dece	dent Ever in U.S	. 13.		Hispanic Origin? (s pan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		14. Race - Ame Black, White	
ဖွ	ter de , or ite	by F	1 🗆 Never Marr		If Voc (all)	e	- 1	1 ☐ Yes 2 🛣 N				Specify: WH	ITE
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show in protections of the control	Completed	3 🗌 Widowed	15 Decede	Year or Da	ites.	16a. Dece	edent's Usual Occi	upation	orking	16b. K	ind of Business	
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ore	ge 1 ar t of He If iter or oth		20a. Method of Dis	X Cremation	3 Removal from	State	emetery, cr	ematory or other p	lace) ATION 12/				LE, MARYLANI
Baltimore,	nit. Pag artmen ortant injury		4 ☐ Donation 21. Signature of F			CH		22. Name and Add	ress of Facility	TN S NEW	NΔM	FIINERAT	HOME, P.A.
Ba	Depart any any any		Ke	ik D	ablen	bein)		130 SEFF	K KUAD CI	TESTERTON	119 1	<u>IĀŘÝLAND</u>	21620 Approximate
			shock, or he	art failure. Lis	or complications that tonly one cause on e	caused the deaf ach line.	h. Do not e	nter the mode of d	lying, such as card	ac or respiratory a	A -		Interval Between Onset and Death
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0.	s that gned k	by P	Part II. Other sign	nificant cond	itions contributing to	death but not re	esuning in a	le dilderlying cade					Probably 4 Unknow
rds	equire seen si hould	eted								24a. W	as an topsy	prior 1	autopsy findings available to completion of cause of
000	e law r e has b ge 2 s	Jdmo								De	rformed	? death	n? Yes 2 □ No
A R	an: Th rtificat tor, pa	Be C	25. Was case reference examiner?		7.7				6. Place of Death				
7 5	hysici this ce al direc	은	1 🗆 Yes	2 No		Inpatient 2	ER/Outpa 28b. Tim	e of 28c.	Injury at	ing Home 5 Re 28d. Describ		jury occurred	весну)
\$ 60	ding F th. After funer	cate	1 Natural 2 Acciden	5 🗌 Per	(0.4	onth, Day, Year)	inju	ry M	work? 1 ☐ Yes 2 ☐ N				- Alaba
Olivision	Atten er dea rector by the	Certificate:	3 Suicide 4 Homicid	6 🗆 Co	uld not be ermined 28e. Pla bu	ce of Injury - At	home, farm	, street, factory, of	fice	28f. Locatio City or	n (Street Town, St	and Number or ate)	Rural Route Number,
SE SE	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Medical C	29a. Certifier	1 Certify	ying Physician: To th	e best of my kno	owledge, de	ath occured at the	time, date and pla	ace, and due to the urred at the time, da	cause(s) and manner as ace, and due to t	s stated. the cause(s) and manner sta r as stated.
#	the Ho nin 24 the Fu npleter	Med		3 L Certif	ying Nurse Praction	er: To the best of	my knowled	ge, death occurred	at the time, date a	nd place, and due t		Date signed (M	
	5 ¥ ₹ 5 €		1/\	ind title of c	0 >	ye_		$-\mid v$	0060	301		1917	1)
			30. Name and a	ddress of pers	on who completed c	ause of death (It	emaßa) (Ty	M PriseD 4	SPES	Cloter	MI	ما الم	ns gich
	Rm s	tate	31. Date filed (M	lonth, Day, Ye.	ar) 32	2. Registrar's Sig	nature	post	1				
	Regis	trar		OE) <u>- 5 901</u>	Dress.		17					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year CHRISTILDA MARIE STEWART 12/02/2011 0545 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgamery Silver Spring . Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 579-98-4638 1 □ M 2 🗶 F 48 DC 05/08/1963 show 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits **Funeral Director** 28a-f 1 Yes 2 No DC Washington 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 5225 5th Street, NW 20011 USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian "natural", or itel If Yes, specify Cuban, Mexican, Puerto Rican, etc. o. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 Divorced Specify: Black Year or Dates 27 is marked other than "natur r traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) yrs Librarian Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Stewart Jean Estill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Stewart/mother 5225 5th Street, NW, Washington, DC 20011 Department of Health Important: If item 27 any Injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 12/09/2011 Bladensburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home Signature Funeral Service Licensee 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sepsis with septic shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Cardiac arrest and that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Be Completed by Physician/Medical P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery lor 3 Cther (specify) in the past 12 months?

1 Yes 2 X No Month Year Pregnant at time of death Day the 8 be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 XNo 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🛛 No Other: ျှ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director; After 1 Natural 5 \square Pending 1 Yes 2 🗌 No the Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be gampletely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe D55475 elono hinner 30. Name and address of person who completed pause of death (Item 23a) (Type, Print) Gebremedhin Yohannes, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year, State **DEC 05 2011**

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#23a(a)perMD, 12/15/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death T. 28, 2011 Physician/ 09:51 AM Peter Nicholas Stamos November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year_ If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 216-60-0471 **Director** 1 🛛 M 2 🗆 F Yrs 61 08/08/1950 Washington, DC Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 XNo Halethorpe Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number er than "natural", or items 23a or the Medical Examiner must be Funeral U.S.A. 932 Oakmoor Drive 21227 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ed Forces? þ 1 X Never Married 2 Married X Yes Maryland 21215-0036 1 X Yes 2 □ No Specify: Specify: Year or Dates. Vietnam Completed 3 Widowed 4 Divorced Puerto Rican Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry h and Mental Hygiene.
7 is marked other than "r traumatic event, the Med Social Security Elementary/Secondary (0-12) College (1-4 or 5+) Social Insurance Specialist Administration Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last မ Yvonne C. Domena Nicholas Stamos permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11126 Schuylkill Road, Rockville, Maryland 20852 Nicholas Stamos - Father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 12/02/2011 | Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Thymic Immediate Cause (Final Physician/ Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any leading cause. Enter Underlying Examine Due to or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans Due to (or as a consequence of): 0951Am Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death signed by the at be detached for P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes_2 🔼 N within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗓 No 1 🗓 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred iniury 1 X.Natural 5 Pending Division Accident 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆

10+1

1102/824

PETER

STAMOS

State Registrar 29b. Signature and title of certifier

N4597

Yuneng Oswald Li.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2011

M.D.,

29c. License number

D67986

8600 Old Georgetown Road, Bethesda, Maryland 20814

29d. Date signed (Month, Day, Year)

November 28, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/25/2011 Physician/ 1324 Humberto Gabriel Soriano Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1324 Montgomery Shady Grove Adventist Hospital Rockville Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) 220-55-4063 Director 1 XM 2 □ F 53 11/14/1958 Nicaragua Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 💢 Yes 2 🗌 No MDGaithersburg Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20879 United States 18600 Sandpiper Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 1 Never Married 2 X Married by soriano, Humberto Baltimore, Maryland 21215-0036 Specify: Caucasian If Yes, Give Year or Dates 1 X Yes 2 □ No Specify: Nicaraguan Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) omputer Designer Mortgage Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked of ပ Maria Manuela Gavache Augusto Soriano injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Vilma Sofia Soriano/ spouse 5 Montgomery Avenue, Gaithersburg, MD 20877 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State All Souls Cemetery 12/01/2011 Germantown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Thibadeau Mortuary Service, p.a. 21. Signature of Funeral Service Licenses M00956 Park Avenue, Gaithersburg, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ lymphoma plastic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the at the detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à rombocytopenia Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed cerebovascular accident 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an ate has l autopsy this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner to the basis of my however, control at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) November 26,2011 DD066656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Car Dr Rockville, MD 20850 Fakeye mD Oluwape 0 5 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 41005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 28, 2011 Charles David Smith 6:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 2007 Ruatan Street Adelphi 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months Hours Min 143-18-7547 Director 1 🛛 M 2 🗆 F 86 March 20, 1925 NJ Usual Residence of Deced 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 ☐ Yes 2 🛂 No MD P.G. Adelphi 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 2007 Ruatan Street 20783 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner rmed Forces?

Yes 2 No þ 1 Never Married 2 K Married Maryland 21215-0036 72 hours after Specify: White If Yes, Give Year or Dates. 1941-67 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ae filed with... •al Hygiene. •ar than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Personnel Officer Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F is marked o ပ John Henry Smith Hilda Hokansen traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury control. 2007 Ruatan Street, Adelphi, MD 20783 Margaret Ann Smith/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Arlington National 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State Dec. 2011 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Francis J. 500 Universi Home Inc. Lver Spring, Collins ty Blvd Funeral Home MD 20901 23a. Part 1. Inter the disease, or complications that earsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Lung Cancer disease or condition mos Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events Due to (or as a consequence of): Exami -tansi that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the as IF FFMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? jo Month Pregnant at time of death ed by the a a Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 1 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an 138 page perforn certificate 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 🗓 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 ₹ Natural work? 1 Yes 2 No 5 Pending injury after death Accident Investigation Suicide 6 Could not be Within 24 hours and...

To the Funeral Direct

I shall filled in by ģ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4 62063 12

Registrar

DHMH 17 Rev 06-2011

State

14207 Park Center Drive, #102, Laurel, MD 20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jenel Wyatt, MD
31. Date filed (Month, Day, Year)

DEC 0 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bramer Leon Smith рм 4:45 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital <u>Bethesda</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 579-50-3762 72 Washington, Director 1 1 X M 2 □ F 1939 D.C. May 7, Usual Residence of Decedent 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10708 Glenhaven Drive 20902 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian Black, White, etc. 6 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No 1 ☐ Yes 2 No Specify: "natural", Specify: Black 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Mail Carrier US Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F ၉ Crumblish Smith item 27 is marke other traumatic Margaret L. Childers and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Pearl Smith/Wife Health 10708 Glenhaven Drive, Silver Spring, MD 20902 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or otl Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Dec. 9 2011 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, MD Francis de Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21, Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiorespiratory Arrest Medical Due to (or as a consequence of) Examiner Small Bowel Obstructin Sequentially list conditions, 2/03/2011 Divi to for easie dunariousness off cause. Enter Underlying Cause (Disease or injury Hypernatremia that initiated events resulting in death) Last Due to (or as a consequence of) for use as the burialttending physician Physician/Medical 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏄 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 2 🖾 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 🖾 No ဂ္ 1 🏝 Inpatient 2 🔲 ER/Outpatient 3 🔲 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending work? 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

Division of Vital R e Hospital or Attendii 24 hours after death. e Funeral Director: A within 2

> State Registrar

31. Date filed (Month, Day, Year) **DEC** 0 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of centile



Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D70241

29d. Date signed (Month, Day, Year)

Dec. 3, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41007 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Soukup Hone November 30 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death or Location of Death **Examiner** HIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min Director 578-48-5332 1 🗆 M 2 💢 F oct. 23, 1936 Washington, DC 75 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be n Funeral **USA** 20707 6005 Windham Road 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 Divorced Completed White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CIA Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thaddeus Stevens Hess Catherine Scheytt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 6005 Windham Road Laurel, MD 20707 Merlyn Soukup/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth Date 20c. Location - City or Town, State Huntt Crematory or other place) 1 Burial 2 XCremation 3 Removal from State 12/3/2011 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleck Funeral Home M00544 7601 Sandy Spring Road Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreutiz disease or condition resulting in death) metastatic Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): the burialattending physician Physician/Medical requires that the death certificate be Box 68760 as use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown þ Day Year Month Pregnant at time of death 5 Other (specify) the 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an the Hospital or Attending Physician: The law in the Law in 24 hours after death.

The Funeral Director: After this certificate has Empletely filled in by the funeral director, page 2 s autopsy Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ပ 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manneryof Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 5 Pending Natural 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complete 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year 11,30,1 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St. Baltimore Hallowe Registrar's Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 5 2011 December 11:30 A M Robert James Schick Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7055 Broomes Island Road St. Leonard Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Days Hours Min. New York |03/YTT/YY35 Director 75 047-26-0586 Usual Residence of Decedent filed within 72 hours after death with the Maryland all Hyglene.

Jother than "natural", or items 23a or 28a-f show vent, the Me lical Examiner must be notified at vent, the Me lical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7055 Broomes Island Road 20685 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Law Attorney 1 and 2 should be filed wit f Health and Mental Hygie item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecilia Virginia Gajkowski Joseph Schick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth S. Hicks / Daughter 7055 Broomes Island Road, St. Leonard, MD 20685 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 \square Burial 2 X Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/12/2011 Alexandria, Virginia 22. Name and Address of Facility Raysch Funeral Home, PA. 4405 Broomes Island Road Port Republic, MD 20676 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atherosclerotic cardiovascular disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. (Disease or iinjury Due to (or as a consequence or) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown ed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? panhypopituitarism, diabetes, hypothyroidism, Records, 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown obstructive sleep agree 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Physician: The certificate 1 ☐ Yes 2 🔼 No Yes 2 X 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending work s after death. 1 Tes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and phase, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) attending D0055682 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas M: Wilkinson, Mp, 23130 Moakley St., Leonaratown, Mb dru

10+ State Registrar

Division of Vital

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32. Registra s Signature

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month TUZ Physician/ 07:52M Medical 4c. County of Death Aa, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Mandrin Inpatient Care Center Harwood 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Days Hours (Month, Day, Yea 3/3/1934 Virginia Director 231-38-1804 Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Maryland | Anne Arundel Edgewater 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21037 USA 3232 Rolling Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? ģ 1 Never Married 2 Married 1 Tyes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Floral vears Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Jessie Wrigglesworth Edward L. Sutor, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jadene L. Payne/ Daughter 2333 Maytime Drive, Gambrills, Maryland 21054 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State 12/5/11 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Auset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2.8 completed filled in by the funeral director, page 2.8 performed? Yes 2 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending work? 2 🗌 No ☐ Accident☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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OF Name and address of personal TENEULEUE

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 5.05 AM Thatcher December 2011 Katherine H. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Havre de Grace
If Under 1 Year | If Under 24 Hrs. Harford Citizens Care Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours 1 □ M 2**X**□ F Director April 21, 1916 Washington, D.C. 95 185-38-8011 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Bel Air MD Harford 10g. Citizen of What Country? 10e. Street and Number 2405 Eagle View Drive U.S.A. Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ∭YNo Specify: White 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ould be filed wromed Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home. permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Hoffman Mildred Richmond မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 Eagle View Drive, Bel Air, Maryland 21015 Alan G. Thatcher (Son) Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montoursville Cemetery 12/10/2011 Montoursville, PA 22. Name and Address of Facility Spitler Funeral Home, Inc. 733 Broad St., P.O. Box 147, Montoursville, 23a. Part 1. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Disease mmediate Cause (Final Physician 0 disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions Due to (or as a consequence of) Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by Old ale 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed' death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 I Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖼 🗸 🗸 🗸 🗸 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours fiter death.

To the Funeral Lirector After this completely filled in by the funeral dir Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number D32609 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier main 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kannely Mithans To 1606 Kevalution St Have De Grace MD21018

Registrar DHMH 17 Rev 1/2001

State

Military 150

32. Registrar's Signature

anniday

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1 / 30 / 2011 Year Physician/ 5:30 PM John R Thompson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Northampton 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Funeral Months Hours 1 🔀 M 2 🗆 F MT7571930 Maryland 220-26-5985 Director 81 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c, City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Frederick Brunswick 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21716 519 East Potomac Street USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) School Board Bus Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျပ Jesse Claggett Thompson Grace L Barger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important. If item 27 is any injury or other tra 317 East D Street, Brunswick MD 21716 Jesse Thompson, Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 12/2/11 Hagerstown MD Signature of Funeral Service Licente 22. Name and Address of Facility John T Williams Funeral Home, Brunswick MD 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Accident ASCULAN ENERMAL Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consquence of Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier D4795

State

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31. Date filed (Month, Day,

Registrar

Toll

House Ave.

814

Registrar's Signature

Therenuc

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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KAZMI, HP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 17 Day 5 Physician/ Zo Li MARGARET THOMPSON CECELTA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ST. MARY I'YSAMM TZ LEONAROTOWN HOSPETAL If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 7 – 1 1 – 1 9 0 9 Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Country) MD Min. Months Hours 1 🗆 M 2 🔀 F 102 213 46 9395 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director 1 Yes 2 No MD St. Mary's Chaptico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ed other than "natural", or items 23a or event, the Medical Examiner must be a Funeral USA 20621 36283 Millpoint Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 🗗 No Black White, etc. þ 1 Never Married 2 Married filed within 72 hours after of al Hygiene.
d other than "natural", or Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 6th College (1-4 or 5+) Private Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any Injury or other traumatic event 17, Father's Name (First, Middle, Last) ပ Margaret Thomas John Frank Briscoe 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 24715 Sotterley Rd. Hollywood, MD 20636 19a. Informant's Name/Relationship (Type, Print) Alvin J. Thompson/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart Cem. 12/12/201 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Bushwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service License 2294 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure, list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRHYTHMIA Physician/ HEART disease or condition resulting in death) Medical Due to (or as a consequence of): 2-3 0445 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an MYACRTICALIZON prior to completion of cause of death? autopsy page 2 performe RE CURCITATION TRICUSPED 1 Yes 2 No certificate 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 12 No ပ 1 Nation 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 1 Natural 5 Pending Accident 1 Yes 2 🗌 No 24 hours after death. Funeral Director: A Investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title 2011 MO LIECTARISTOWN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROTHT LOOKOUT ROAD 20650 RUBERT 25500 SRUCE GIBSON MP

Registrar

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2. Registrar's Signature

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			For State Registrar			a, , , a, , a			te of D		and w	TOTAL TITY	Reg. No	20		41014
	Physicia Medic			augherty	Treanor							2. Date of De Month Novembe	_	Š, 20	Year 11	3. Time of Death 3:40 A. M
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	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year)								1919	9. Birth	place (State or Foreign			
	show dat	Į.	Usual Residence of 10a. State	10b. County		10c. City, T										0d. Inside City Limits
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	with the s 23a o	Funeral Director	3700 Inte		al Drive				0906			!	-	tizen of W ted S		•
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Marri 3 Widowed		12. Was Decedent I Armed Forces? 1		11	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 No Specify:						14. Race - American Indian, Black, White, etc. Specify: White		
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212	within ygiene.		Elementary/Seco		College (1-4 or 5 5+	s+) S	peech		,	ring	Dire	ctor	Pul	olic	Scho	ools
Maryland	ald be filed Mental Hy narked oth	To Be	Harry H.	7. Father's Name (First, Middle, Last) Harry H. Pringle					18. Mother's Name (First, Middle, Maiden Surname) Ethel Bray							
, Mar	nd 2 shou lealth and m 27 is m			h Treand	(Type, Print) or/Daughter		151 F	River	Chas	se Ci	rcle	, Sacran				,
Baltimore,	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra				Removal from State	Georgian Medi	e of Dispos GETOW Cal C	sition (Na VIII ^{PT} /UI Cente	ame of other place ITVET: EX	sity	Nov. 201	² 25	Wasl	ningt	on,I	
Balt	permit Depart Import any inj		21. Signature of Fur	neral Service Lice	ensee	M00969	22	. Name a	and Address	s of Facilit	Colu	mbia Mo , Lanha				ces, P.A.
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)										Approximate Interval Between Onset and Death						
	Medical Examiner		resulting in death)		Due to (or as	a consequen	ce of):									
]	The d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.													
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Division of Vital Records,	The lavate has						-					24a. Was autoperfor	psy ormed?	pi de	ior to co	psy findings available mpletion of cause of
ital	ysician: is certific director,	Be	25. Was case referre examiner?	_	Hospital:		_		Other	ce of Deat						
of V	g Physer this neral di	Certificate: To	27. Manner of Death 28a. Date of injury 28b. Time of						28c. Injury at 28d. Describe h				dence 6 Other (Specify) now injury occurred			
ion	tendin Jeath. tor: Aft the fur		1. ♣ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be					M 1 ☐ Yes 2 ☐ No								
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	To the Hospital within 24 hours a To the Funeral C completed filled i	Medical	(Check 2	Medical Example Medical Exa	nysician: To the best of miner: On the basis of ex urse Practioner: To the	kamination an	id/or investi	igation, in	my opinior	n, death oc	curred at	the time, date a	and place	, and due	to the car	use(s) and manner stated.
	To the vithing to the complete	_ ,	29b. Signature and t	itle of partifier	10950	•		29	c. License	number				te signed		
	2		30. Name and addre	ss of person who	completed cause of de	eath (Item 23	a) (Type, P	rint)			- 10		1.2	-10	11	
	- 01-		Sunit	Day Year	garilki, 9 8	r's Signature	iprop	a A	wyw	1#1	-17,	sil ve	V163	ing	01	120902
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2011 Thomas Joseph Tawney Dec 7:01 Medical a 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days (Month, Day, Year) **Director** 1 🛛 M 2 🗆 F 64 578-64-0549 6/28/1947 DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturor" any injury or other traumatic events. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 114 Bert's Lane 20711 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates. 66-68 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ 1 ☐ Yes 2 X No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Steamfitter 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3165 Ponds Wood Rd., Huntingtown, MD 20639 Theresa White/Niece 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 12/6/11 4 Donation 5 Other (Specify) Beltsville, MD Chesapeake Crem. 22. Name and Address of Facility Signature of Funeral Service Ricensee Raymond-Wood F.H., PO Box 430, Dunkirk, MD 20754 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Live Birth 2 ☐ Fetal dea:
☐ Pregnant at time of death for Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy perform 1 Yes 2 No certificate the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ Anpatient 2 ER/Outpatient 3 DOA 1 Tyes After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Accident **A**tural 5 Pending 2 🗌 No Investigation 24 hours after death Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check within 2 only one) Certifying Nurse Practition To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature ar 29c. License numb

State

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person

31. Date filed (Month, Day,

pleted cause of deathy(Item 23a) (Type, Print)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month NOVEMBER 2011 10:20 PM MYRTLE DINAH TILLEY Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death 2209 BARCLAY ROAD BARCLAY OUEEN ANNE'S Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Days (Month, Day, Year) 08/12/1925 Months Hours PANAMA CANALZONE Director <u>1</u>10-18-4208 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD OUEEN ANNE'S BARCLAY 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2209 BARCLAY ROAD 21607 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 24 No Black, White, etc. þ 1 Never Married 2 Married Yes (Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Divorced 4 Divorced Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY SECRETARIAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ LESLIE GLASGOW MARJORIE CRAIGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIE TILLEY / HUSBAND 2209 BARCLAY ROAD BARCLAY, MARYLAND 21607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUDLERSVILLE CEMETERY 12/02/2011 SUDLERSVILLE, MARYLAND 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME. P.A. 370 W. CYPRESS STREET MILLINGTON, MARYLAND 21651 21. Signature of Funeral Service Licensee art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Interval Between Immediate Cause (Final Physician/ Adamo carcin oma of the Lung MotaStatic month disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of,: Exami spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eath Director After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Other (specify) 4 ☐ Pregnant a 1 Yes 2 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by + Choli Peripheral Vasc D 2 No 3 Probably 4 Unknown 1 X Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2. No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 14 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical 29a. Certifier 1📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0050996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holder TM 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 7/2009

Medical Certification: To within 24 hours after death

To the Funeral Director: To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WD D69568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pockville, MD 6121 Montrose Road A. Chila kamazza 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 0 5 2011 Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 6:00A 2011 Jean Baker Wilson Dec. 03 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Buckingham's Choice Adamstown Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Months Hours 579-24-0054 Director 1 □ M 2 🔀 F Dec. 24, 1923 87 Maryland Usual Residence of Deceden 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director notified 1 Yes 2 X No Maryland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r Funeral 3200 Baker Circle 21710 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter edical Examiner Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the alth and Mental Hygien

27 is marked other ther traumatic event, the School Teacher Teaching Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Andrew Baker Laura Belle Foard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Baker - Nephew 5 Winifred Court, Burtonsville, Maryland Department of Health Important: If item 27 any injury or other troone. 20866 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 【XCremation 3 ☐ Removal from State cemetery, crematory or other place) Metropolitan Crematorium 12/6/11 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) . Signature of F/n ral Service Licens 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Atheroscleratic Vascular Disease Onset and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to include cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence or) Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) attending physician for use as the buria Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FFMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ♣ No Month Day Year Pregnant at time of death ed by the a detached f signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Matural 5 Pending Investigation Accident 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only o 29b. Signa 29d. Date signed (Month, Day, Year) re a 12-5-2011 D0058726 lress of person who completed cause of death (Item 23a) (Type, Print) 10 30. Name and ac Ventrie Ct. Myersville MD 21773 3000-D Warren MO 32 Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death K Wells Physician/ Robert Jr. Month 1840 M 2011 11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Anne Arunde Burne, Glen 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y March 11 9. Birthplace (State or Foreign **Funeral** Months 60 Virginia **Director** 224-72-9316 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland 10c. City. Town or Location notified at 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 104 Hatton Drive 21146 USA "natural", or items edical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Vice President of Sales Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fay Perkins Robert K. Wells, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Wells / Wife 104 Hatton Drive Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. cemetery, crematory or other place, 1 ☐ Burial 2 💢 Cremation 3 🗀 Removal from State Metro Crematory, INC. 2011 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
Soverna Park MD 21146 21. Signature of Funeral Service Licensee Severna Park, MD 21146 495 Ritchie Hwy, 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or legar failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

Hours Immediate Cause (Final disease or condition resulting in death) myo cardial infaction Ph_sician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): s been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year 4 ☐ Pregnam

9 ☐ Unknown 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hyperlipidemia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Inpatient 2 FR/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0068619 11-27-2011

Registrar

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State

31. Date filed (Month, Day, Year)

DEC 0 1 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital Drive, Glen Burme, MD Christina Bennett-Fee 301 Hospital Drive, Glen Burme, MD

			Please Type	or Print in Blac	k Indelible Inl	k. Ensure Al	I Copies A	re Legible.				
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			State Registrar		Certificate of L	Death	Reg.	No. 201	1 4 102			
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	eath v	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-									
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lan.	12 should be file lith and Mental H 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street	and Number or Rural i	Route Number, City	y or Town, State, Zip	o Code) 20903			
≥	and 2 Health em 27 ther t		Bok Youn Yi/Spouse		100 New Hamp							
Baltimore, Maryland 21215-0036	Page 1 anent of H ant: If ite		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal fr	rom State cemeter	Disposition (Name of y, crematory or other place			c. Location - City or				
Hin	nit. Pa artmer artant artant injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Meteropo	olitan Crem.				, Virginia			
Ba	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		21. Signature of Puller's Service Licerises	li like	22. Name and Addres				MD 20877			
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89	certif ending use a		IF FEMALE: 23c. If yes, 23b. Was decedent pregnant 23c. If yes,	23d. Date of de	23d. Date of delivery							
Box	death he atte	sicia	1 Yes 2 No	live Birth 2 ☐ Fetal death Pregnant at time of death Inknown	3 ☐ Ectopic pregnance 5 ☐ Other (specify)		Month Day Year					
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၁၁ခ	e law has l						24a. Was an autopsy performed	prior to	completion of cause of			
Ä	n: The ificate or, pag		25. Was case referred to medical		ace of Death (Check o	1 Yes 2 No 1 Yes 2 No						
Vita	Physician: The law requires that the this certificate has been signed by the director, page 2 should be detach	To Be	examiner?	☐ Inpatient 2 ☐ ER/Out	er.	Jursing Home 5 Residence 6 □ Other (Specify)						
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Visi	of or Attend after death Director: A d in by the f	Serti	4 Homicide determined 28e. Pla	ace of Injury - At home, fan uilding, etc. (Spec <i>ify)</i>	m, street, factory, office	28	8f. Location (Street City or Town, St	Street and Number or Rural Route Number, vn, State)				
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	To the Hospital or A within 24 hours after To the Funeral Direct completed filled in by	Medical	29a. Certifier 1 X Certifying Physician: To the (Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Practions	basis of examination and/or	investigation, in my opinio	on, death occurred at the	he time, date and pl	ace, and due to the	cause(s) and manner stated.			
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			30. Name and address of person who completed c	ause of death (Item 23a) (T	•							
			Daniel I. Kim, M.D., 59 31. Date filed (Month, Day, Year)	008 Hubbard I	Orive, Rocky	ville, Mar	yland 208	852				
	Stat	е	NFC 0.6 2011	2. Registrar's Signature	sales.							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Antoine Naim Zelof Nov. 2011 12:15 A M 28 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 12, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 224-96-5351 **Director** 1**X** M 2 □ F 74 Isreal Usual Residence of Decedent show 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location notified at Director Maryland Montgomery Germantown 28a-f 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 20876 USA 10434 Breezedale Ln. items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian. the Medical Examiner Armed Forces?

1 Yes 2 No Black Middle þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Eastern 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Computer Specialist Elementary/Secondary (0-12) College (1*4 or 5+) Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Naim Abouzelof Bahia Ghanam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samer Zelof/Son 15544 Peach Leaf Ln., N. Potomac, MD 20878 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Inc 11/29/2011 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hampstead, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctonic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month 5 Other (specify) Day Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the C24 hours after death.
Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 autopsy
performed?

1 Yes 2 XNo 1 ☐ Yes 2X No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 5 Pending iniurv 1 XNatural Accident Investigation completely filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/28/2011 WJL 3 7142 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
G. Coleman MD 6001 Muncaster Mill Rd., Rockville, MD 20855

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

NOV 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician ERALDINE KINSON December 17th 13:01PM 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Randallstown <u>Baltimore</u> 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06-10-30 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Days 81 NC Director <u>237-50-6501</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show fural", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes X No Director MD Baltimore Windsor Mill 10e. Stress and Number 10g. Citizen of What Country? 2 hours after death with 3500 Jean Drive 21244 USA Ineral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. African 1 ☐ Never Married 2 ☐ Married altimore, Maryland 212 5-0036 1 ☐ Yes **X**[X]No Specify: þ Specify American 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry the Med (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Teacher Aid NA<u>City of Baltimore</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joshua Plaze Stowe Bessie Green Mae ဂ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 Avis Atkinson McCullough 3500 Jean Drive Windsor Mill. Maryland Date Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD. Nat'l Cem. 12-24-11 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee the 638 N. Gilmor Street Baltimore, MD 23a. art1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure list only one cause on each line.

Immediate Cause (Find disease or condition resulting in death)

a.

Due to (or as a consequence of): 21217 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to infinite date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Particular Secution of the properties of the properties of the properties of the physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Ye ar 4 Pregnant at time of death 5 Other (specify) P.0. 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Uninwy fruit injection 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 1 □ Yes 2 1No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 11 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 17th, 2011 1854

State Registrar

DHMH 17 Rev 1/2001

NORTHWEST HOSPITAL, RANDALIS TOWN, MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

PATEL

NILESH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ASCHER December Medical a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE VA REHABILITATION AND EXTENDED CARE CENTER N/A BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 X M 2 - F Months Days Hours Country) 08777771924 87 MD 217-18-2800 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2X No MD BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6614 DALTON DRIVE 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in ILS 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) uld be inc_ d Mental Hygiene. - → **∼ther than** "r Elementary/Seconday (0-12) College (1-4 or 5+) iit. Page 1 and 2 should be filed withi artment of Health and Mental Hygien ortant: If item 27 is marked other th injury or other traumatic event, the ELECTRONICS TELEVISION TECHNICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CHARLES ADLER **CECELIA** LEVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CALVIN ADLER/SON 6614 DALTON DRIVE, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State MD VETERANS CEMETERY 12/21/2011 4 Donation 5 Other (Specify) OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licensee Men Le 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ BLADDER disease or condition resulting in death) Medical ue to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) 1 ☐ Yes 2 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 After this certificate 25. Was case referred to medical director. 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined To the Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar DEBEA.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

46,MER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Ande 0/45 AM G(2.5.4h Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 36 Homene Keswick namory 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 21 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2X F 214-18-2949 Director 89 May Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nand Mental Hygiene. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore City 1 X Yes 2 No MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8820 Walther Blvd. #4412 United States 21234 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 XNo
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced White Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Art Department Pentagon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Mueller Francis P. Lynch Sister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh Iment of Health a tant: If item 27 is Mrs. Catherine L. Haynie 21234 8820 Walther Blvd. #4412 Baltimore, MD 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 😡 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 D Other (Specify) Ht. of Jesus Cem. 12/22/2011 Dundalk, MD 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signatur uneral S Dundalk. Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician | at the oschestil disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 1 | Yes 2 | 9 | Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12-200 205918

Registrar

State

31. Date filed (Mohth, Day, Year)

2 2 201

address of person who completed cause of death (Item 23a) (Type, Print)

505

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DEC. 2011 18, 9:40 P M ANNA CATHERINE AUGHINBAUGH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE STELLA MARIS HOSPICE TIMONIUM If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) **Director** 86 219-18-4698 1 □ M 2 **X** F 4/25/1925 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at by Funeral Director Y☐ Yes 2 ☐ No MD N/A BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Ç **23**a USA 21201 1 W. CONWAY ST. APT 108 Page 1 and 2 should be filed within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married WHITE 1 Yes 2X No Specify: Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME Be Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) MARY K. GAGLIO GUISEPPE PALUMBO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 BOUNDING HOME CT HAVRE DE GRACE, MD 21078 permit, Page 1 and 2 Department of Healt Important: If item 2 any injury or other i NORA REEDY-DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 12/22/11 FALLSTON, MD HIGHVIEW Donation 5 Dother (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BELAIR 610 W. MACPHAIL RD BEL AIR, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death 5 Other (specify) Month g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **X** No 1 Tes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မှ 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 🕱 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093

DHMH 17 Rev 06-2011

State Registrar

2300 DULANEY VALLEY RD.

CRNP

JACKIE JONES, 31. Date filed (Month, Day, Year)

DEC 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\Omega\) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** December 2011 William Russell Baldwin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-14-1953 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Days Months 1√2 M 2□ F NC 58 215-60-4896 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be motified at 1 Yes 2 No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 USA 421 Poplar Grove Street Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 Specify: 1 □Yes 2□No þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Dept. of Water d 2 should be filed w th and Mental Hygie 7 is marked other th 12 Mother's Name (First, Middle, Maiden Surname) Anna Jane Cato 17. Father's Name *(First, Middle, Last)* Robert Lee Baldwin Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Pages 1 and 2 457 Bitmore Rd. Whiteville, NC 28472 Anna Cato/mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Mt.Carmel Cemetery 12-23-11 Baltimore, MD 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Phillip A Weatherford FS PA 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2431 E Oliver St, Balto, MD 21213 Approximate Interval Between Onset and Death Immediate Cause (Final Day **Physician** neymonia resulting in death) /Medical De to (or as a consequence of): Examiner pertension Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last accident e re brovasculas physician and s the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical attending p for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Diabete Mellita Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No Jas page 2 certificate 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2∭XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of certifier MD dist dame December 14 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) d 900 Caton Avenue, Baltimore, MD 21229 Anii Nadipelli 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 Thomas C. Bethune Jr. 6:06 A M Dec 22 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-16-1941 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1X M 2 🗆 Hours Country) 229-48-5841 70 Director VA Usual Residence of Decedent 28a-f shov 10a, State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified WV Ritchie Pennsboro 1 Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 381 Bethune Lane 26415 USA death \ 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: "natural", Specify: white 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Engineering Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked Thomas C. Bethune Sr. Dorothy Johnson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Bethune-wife Bethune Lane, Pennsboro, WV 26415 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or South Carroll Crem 12-23-11 Sykesville, MD Signature of uneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home any Nomas 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each lipe. t enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ch line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): and -fransit Exami Due to (or as a consequence of): resulting in death) Last -burialattending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Pregnant at time of death ed by the Yes 2 No 1 Yes 2 L Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 3 29b. Signature and title of cert 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar Herbert ().
31. Date filed (Month, Day, Year)

30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

92

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Thomas James Barrett Medical December 19. 2011 9:29 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 815 Young Place Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Day, Hours Director 407-04-7107 1 X M 2 🗆 F 55 Sept 5, 1956 California Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9 must be Funeral 23a 815 Young Place 21702 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Force Black, White, etc. ö ģ 1 K Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural" 3 Widowed 4 Divorced Completed White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. I other than " event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked ot r other traumatic even ၉ Charles Arthur Barrett Helen June Wildberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 815 Young Place Frederick, MD 21702 Michael C. Barrett / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/21/2011 Woodbine, Maryland 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Obstraction Onset and Death Immediate Cause (Final Bowel Ph si ian disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Examine Due to (or as a consequence of) nding physician and use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? 1 Yes 2 No Yes 2X No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home 5}\) Residence 6 \(\text{Other}\) Other (Specify) 1 ☐ Yes 2 🗓 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) P4309 12-19-11

Registrar
DHMH 17 Rev 06-2011

State

TOLL House Ave, Frederick, MO 2170/

30. Name and address of person who completed gause of death (Item 23a) Type

h, Day, Year) 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2011 9:30 A M Cooke Ballou Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Months 096-14-1573 91 **Director** 1 □ M 2 🗓 F 03/25/1920 NY Usual Residence of Deced 28a-f shov 10d. Inside City Limits notified at 10a State 10b. County 10c. City. Town or Location Director 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Examiner must be 23a Funeral Hamilton Street 2011 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 5 1 Never Married 2 Married by 2**X** No Baltimore, Maryland 21215-0036 72 hours after Black nan "natural", o Medical Exan 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4 or 5+) the US Patent Office Supervisor Hygier other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ige 1 and 2 should be filed int of Health and Mental H I: If item 27 is marked of မ Samuel Cooke Margaret Edmonds traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9810 Arbor Hill Drive, Silver Spring, MD 20903 Wendy Hodge-Graham/Daughter other t 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department (Important: If any injury or injury or 12/27/2011 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. Brentwood, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Marshall-March Funeral Home Tanes 4217 9th Street NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Angroximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Aspiration Pneumonia with Hypoxemia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hypernatremia certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Pulmonary Embolism, Ventricular Tachycardia Episode Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 9 Unknown ed by the a 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 certificate has performed' 1 ☐ Yes 2 🕱 No Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 🔀 No 1 Yes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: or Attending 1X Natural 5 Pending 1 🗌 Yes 2 🔲 No filled in by the Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after within 24 hours a

To the Funeral D

completely filled i the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) malvii-12/19/2011 D66372

Registrar

DHMH 17 Rev 06-2011

State

1500 Forest Glen Rd. Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Majid Rahmanirnshahri,

31. Date filed (Moran, Day, Year)

MD

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 41030 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 19, 2011 4:24 P Roger Lee Brewer Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Air Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. **Funeral** Months Hours Min (Month, Day, Year) Director 219-42-2498 1 😿 M 2 🗆 F Apr. 7, 1946 Virginia 65 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 ☐ Yes 2 🔀 No Maryland Harford Joppa 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? event, the Medical Examiner must be 23a Funeral 1102 Joppa Farm Road 21085 USA or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify. "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Concrete Manufacturer Construction Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Lena Mae Sawyers Thomas Edward Brewer injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. MD 21085 Shirley K. Brewer / Wife 1102 Joppa Farm Road, Joppa, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 K Cremation 3 ☐ Removal f m State Donation 5 Cher (Specify) Hilltop Service Corp. 12-22-2011 Towson, Maryland ture of Funeral S 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sigr Þ 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. et and Death Immediate Cause (Final Physician/ oronary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it amples along to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Brewer, Roger Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Palmonary disease CHRONIC OBSTRUCTURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an cabetes, autopsy performed Yes 2 4000090336 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 X Yes 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Sgnature and title of certifier Date signed (Month, Day, Year) H41069 2011 anjey of death (Item 23a) (Type, Print) NOOD ヒロ State 2 2 2011 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 Amend Items 23aPtI,II,25,27,28a-f per me.g922,12/19/20Ildhb,16b 1 - State Registrar per FH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Scaul 2111 2011 IIma /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimare Baltimore N/A Of tal If Under 1 Year | If Under 9. Birthplace (State or Foreign Social Security Number 213-32-8924 7. Age (In yrs. last birthday) **Funeral** 10/24/1935 N. Min. 1 □ M 2 □X Months Days Hours Carolina 75 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show Examiner must be refilled at 1XYes 2 □ No Director N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 827 Arlington Ave. Apt 108 21217 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. 1 Never Married Married 1 ☐Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AVA AVA unk Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Harvey C. Hill Rose Mae Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Brown(daughter) 806 Bayner Rd., Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit, Pages 1
Department of H
Important: If itel
any Injury or oth 1 ☐ Burial 2 IxCremation 3 ☐ Removal from State on-site Crematory09/01/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 365€9HddHs.ofBYOwn Jr. Funeral Home PA SOWN 2140 N. Fulton Ave., Baltimore, MD 21217 Approximate Interval Between Onset and Death 21a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imm liate Cause (Final oronavy **Physician** 2011 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) physician the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Pelvic Fracture, Ankle Fracture 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 100 Certification: To 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred August 23,2011 Unknown p

August 23,2011 Unknown p

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Natural 5 Pending Subject fell. Natural

Accident 1 ☐ Yes 2 No after death. investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Unknown Unknown within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my estated. 29a. Certifier Medical (Check o Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number

State

Saw

2121

Baltimore, Maryland

requires that the death certificate be executed

Records,

ivision of Vital

or Attending

Hospital

Known

Registrar

DHMH 17 Rev 1/2001

30. Name and a

31. Date filed (Month, Day, Year)

WASHINGTON

dre person who com leted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PM 1143 Bonaparte December Addie 2011 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore A gnes NA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) SC 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 M 2X F Months Hours (Month, Day, Ye 54 Director 78-50-3145 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director XX Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Examiner must be Funeral items 23a Mt. Hollev 21229 511 Street USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. African Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: American the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 11th Grade College (1-4 or 5+) Private Duty Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Linsay Riddick Sarah Bonaparte 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 Edmeena F. Riddick 3221 Westmont Street Baltimore, Maryland injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1 a
Department of H
Important: If ite 1 Burial 2 Cremation 3 Removal from State Metro Crematory or other place) 12-22-11 Catonsville, MD 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. any in 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List 4 Nours Immediate Cause (Final Edina Pnysician ulmonary disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate can be fined underlying Examine Due to (or as a consequence of): for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 4 ☐ Pregnant a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has birector, page 2 s autopsy performed? Yes 2 N 2 🗹 No 1 Tyes within 24 hours after death.

To the Funeral Director. After this certifical completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 5 Pending injury X Natural ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 🗌 Homicide determined Medical 🛮 😿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) NP1 135665903 2011 Recenter MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

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32. Registrar's Sigr

Year 2 900 Caton Avenue.

Baltimore

11-09498 DOYUN
UNKUNK BOTHS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ 0158 hrs **Medical Examiner** December 18, 2011 Barnes Dayon 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital NΑ 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director 03-25-84 Country) 215-06-5919 27 MD 1 X M/ 2 F Usual Residence of Decedent 10d. Inside City Limits in, 10a. State 10b. County 10c. City, Town or Location XX Yes 2 No 23a or 28a-f show MD NABaltimore with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4545 Manorview Road 21229 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. African If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married 1 Yes 2 X No specify: American 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year ₫ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than ", injury or other traumatic event, the Medical R Baltimore, MD 21215-0036 NA Unemployed 11th Grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Barnes, Jr. Bernadine Parker æ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4532 Manorview Road Baltimore, MD. 212<u>29</u> Tyshell Barnes, Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) t. Zion Cem. 1 X Burial 2 Cremation 3 Removal from State 12-28-11 Lansdowne, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Wylle Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 Approximate Interval 23a-Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause or Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit d. cian/Medical the attending physician ed for use as the burial -UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, ital of Attending Physician: The law requires that the death certificate be ure after death. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death Month Year 1 Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Physic 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Dec 18, 2011 After 27. Manner of Death 28b Time of Injury 28c. Injury at Work? Certification Subject shot 1 Natural 0048 hrs To the Hospital or Attendin within 24 hours after death.

To the Funeral Di ector: A completely filled in by the fu 1 Yes 2 ✓ No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State)
200 block of N. Smallwood Street, Baltimore, MD determined (Specify) Local Street 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert December 19, 2011 O.C.M.E dee ste 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Manth, Day Year) 201 Registrar's Signat State Registrar

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41034 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 18, Physician/ Month John Bishop 0452 PM December 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore University of Maryland Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 X M 2 🗆 F Months Days Hours Min (Month Day Year) 09/06/1950 214 54 2873 Director 61 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f s 1 X Yes 2 No N/A Maryland Baltimore 10e. Street and Number F 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral death with 1349 Herkimer Street 21223 U.S. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Yes Yes 2 No permit, Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the M Amtrak Railroad Trackman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Albert Bishop Sr. Emma Bishoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Max Buettner Jr. / cousin 3785 Country Club Road Crisfield, Maryland 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🗆 Burial 2 🛭 Cremation 3 🗀 Removal from State 12/21/2011 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Sign to re of Juneral Service Lic 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Assiration disease or condition resulting in death) Duspected Medical Due to or as a consequence of Examiner Sequentially set conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit cirrhosis that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown detached 9 Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, COPD (Suspected 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 2 No ပ္ ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No After 28d. Describe how injury occurred ✓ Natural 5 Pending injury death. Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) , mp D72344 December 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Dina Ismail,
31. Date filed (Month, Day, Year)

QEC 2 2 2011

32. Registra

South Greene Street, Baltimore, Maryland, 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 1 ar December 9:45 A M 18. Marv Backert Elaine Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Quail Run Assisted Living Parkville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min Maryland 216-28-4033 02-29-1932 **Director** 1 🗆 M 2 🗶 F 79 Yrs Usual Residence of Deced 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location be notified at Director 1 Yes 2 X No Parkville Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number ms 23a must be Funeral USA 21234 2605 Proctor Lane items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Black, White, etc. ō þ 1 Never Married 2 Married 2 should be filed within 72 hours are... th and Mental Hygiene.
27 is marked other than "natural", or event, the Medical Exam Yes 2 X No within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bank Teller Banking Industry 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Anna Angnes Etzel Gustav F. Hubert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health as Important: If item 27 is any injury or other traunonce. Parkville, Maryland 21234 Mr. Daniel J. McBride - Nephew 2605 Proctor Lane 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 12-21-2011 Moreland Memorial Park Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Road 22. Name and Address of Facility 21. Signatu Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ementic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the atte Month Day 1 ☐ Yes 2-9 ☐ Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed after death.

Director: After this certificate has 1 Yes 2 N funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Other: 4 Nursing Home 5 Residence 6 2/No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hain 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Certificate: Natural 5 Pending work 1 Tes 2 🗌 No filled in by the ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Contifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALMOUD

32. Registrar's

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31. Date filed (Month.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 03:45 AM Blanton Ellen December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Multimedical Center Towson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 6. Sex Days Hours Min. 1-173h-13 29 Maryland 1 □ M 2 ▼ F 82 Director 215-24-4538 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter a once. 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 X Yes 2 ☐ No Baltimore Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21224 631 S. Eaton Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Trucking Office Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary Anna Olszewski Hugh P. Lannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 631 S. Eaton Street Balto.Md. 21224 William H. Blanton Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, Md. 2-22-2011 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles S. Zeiler and Son Inc. 21 Signatu Fun I Service Licensee Balto.Md. 6224 Eastern Approximate Interval Between Onset and Death Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Distanly one cause on each line. Immediate Cause (Final Sepsis Physician/ one month disease or condition Medical resulting in death) D e to (or as a consequence of): Examiner ommunity Acquired Methicillin Servitive Starty lowers Hurry Preumania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a con quence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 № 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypoxic Respiratory Failure-Ventilator dependent 1 = Yes 2 = No 3 Probably 4 Unknown Chronic Kidney Disease Congestive Heart Failure 24b. Were autopsy findings available Atrial Fibrillation 24a Was an prior to completion of cause of death? performed Yes 2 No Peripheral Arterial Declusive Disease 1 Yes 2 No Hypertension 25. Was case referred to medical examiner?

1 Yes 2 No filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number Muchelle C. Kalendercent R097104 December 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Kalender Genesis mutimedical Center 7700 York Road Towson, MD 21204 lov

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 2 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene dr. 12/22/2011dhb Reg, No for State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Physician/ 150 L 1ce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Homore kingland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year **Director** 1 **X**M 2 □ F 12 1938 Trinidad 04 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Randallstown notified MD 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be r USA 21133 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceden.
Armed Forces?
Ves 2 No 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Black. White, etc. ö ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates Specify: "natural" Completed 3 Widowed 4 Divorced er than "natur , the Medical F 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Univ. of Maryland College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. ibrarian 12th grade Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Usborne Mar Bovce CHEOV DE 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randallstown MD Load avie 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Greenmount Cremetini Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address acility 21123 Road Randa 4Stown MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. dysrhytma Immediate Cause (Final Onset and Death ourdiac Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Hours Sepsis Presumed Frequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician $\#\mathcal{I}\mathcal{A}\mathcal{A}\mathcal{A}\mathcal{I}$ Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examine? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work?
1
Yes 28d. Describe how injury occurred (Month, Day, Year) XNatural 5 Pending
Investigation 2 No Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractitioner. To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractitioner. To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D70853 12-13-11 erson who completed cause of death (Item 23a) (Type, Print)
leman 110 S. Paca Street Swife 200 Baltimie, MD 21201

Registrar

State

Name and addres

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31. Date filed

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Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12 Month 18 Day 2011 Melvin Raymond Brown 6:55p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Gilchrist Hospice Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 220 – 36 – 4792 7. Age (In yrs. last birthday) **Funeral** Hours Director M 2 □ F 70 Yrs. 05/11/1941 Maryland 28a-f show 10c. City, Town or Location the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 □ No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1717 N. Broadway 21213 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ✓ Yes 2 ☐ No ō þ 1 Never Married 2 Married 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry I Hygiene. life. DO NOT use retired) 12th Grade College (1-4 or 5+) Bethlehem Steel Ship Yard and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injuy or other traumatic eve once. ျှ James Brown Margaret Isaac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 E. Federal St., Baltimore, MD 21213 Aaron Brown (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State on-site Crematory12/20/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph de Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Molce Ph_sician/ disease or condition resulting in death) montas Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Day 1 ☐ Yes 2 L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ prostate conces 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence & Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🗫 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signatu o 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANIS h701 N.

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year,

DEC 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2-25P Physician/ Day HASE AYNE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Burtonsville Montgomery Sanctuary at Holy Cross If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Min 10/19/1934 Washington, DC 220-28-6565 77 Director 1 XM 2 □ F Usual Residence of Deced show 10d. Inside City Limits notified at 10a. State 10c. City. Town or Location Director 28a-f 1 X Yes 2 No Howard Co. Columbia 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ems 23a or r must be r Funeral 21044 USA 5460 Mystic Court items ; permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: USA 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Truck Drive Private 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edgar Gant Grace Chase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5460 Mystic Court; Columbia, Maryland 21044 Alice Chase - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/29/201 Beltsville, MD 4 Donation 5 Other (Specify) Chesapeake Crem. 22. Name and Address of Facility Freeman FUneral Services 4594 Beech Road; Temple Hills, MD Enter the disease, or co nolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death or heart failure. List or Immediate Dause (Final disease or condition SEPSI Physician/ Medical resulting in death) Due to (or as Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown Part J. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an this certificate has ral director, page 2 autopsy prior to completion of cause of death? 2 No Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral Americal Americal Division of Vital 25. Was case referred to meetica 26. Place of Death heck only one) Be Other: 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SmITH 835 31. Date filed (Month, Day, Year) State

Registrar

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Victoria	Carroll

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/ictoria Carroll	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2011410
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year
niodiodi Examinio	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Funeral	4316 Elderon Avenue Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director.	213-54-1636 _{1 M 2 XF} 62 Yrs. Months Days Hours Min. 07 01 49 Foreign Country) MD
any	Usual Residence of Decedent 10a. State
E	MD NA Baltimore 1 X Yes 2 N
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merital Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 4316 Elderon Ave 10f. Zip Code 21215 10g. Citizen of What Country? U.S.A
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21215-0036 suld be filed within 7 Mental Hygiene. marked other than the event, the Media.	12th grade 2 yrs Fraiic Enforcement Officer Talking Const. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
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MD 21 d 2 should dith and Mer nn 27 is man numatic ev	Marie Rodriguez-Son 4510 Biddron Mar, 2020
Ore, jes l and of Heal if item	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimore, permit. Pages I as Department of Her Important: If ite	4 Donation Other Specify: On-Site 12/23/2011 Baltimore, Md 21. Signature Funeral Service Pure and Address of Facility
	21. Signature Funeral Service Configer Puneral Service Puneral
Physician Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease Death
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ije	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
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Vital ysician: ysician: his certif director, o Be	25. Was case referred to medical examiner? Hospital: 4 Innation: 2 EB/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene
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To the Ho within 24 To the Ru completely	one) 2 Windical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.
A COL	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. December 20, 2011
2	30. Name end address of person who completed causer of death (Item 23a)
State	Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) DEC. 2 2 2011 32. Registrar's agnature
Registra	DEC 2 2 2011 Chans S. Jacks

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adine Mary Co		State of Maryland / Depa		nd Mental Hy	giene	201	1 4104
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Physicia Iedical Exami		Nadine Mary Cotton		1	2. Date of Death Month December	Dav Year	3. Time of Death 1903 hrs
)			4b. City, Town,	or Location of Death	December	4c. County of Death	-
		4a. Facility Name (if not institution, give street and number) 501 Street 1205	Baltimore			N/	/ A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la			8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or Foreign untry)
Director		218-46-5072 1_M 2 X F	62 Yrs. Months Da	ys Hours Min.	9/4/19	49	MD
'n		Usual Residence of Decedent					40d to ide Oit timite
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with the s 23a c noti	eral	501 Dolphin Street Apt 1205 11. Marital Status 12. Was Decedent Ever in U.	.S. 13. Was Decedent of F		cify Yes or No-	USA 14. Race - Americ	can Indian, Black,
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after o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 N	lo specify:		Specify: Bl	ack
5-0036 led within 72 hours Hygiene. nther than "natur	g	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup during most of working li			16b. Kind of Business/I	ndustry
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215-0036 be filed within 7 ntal Hygiene. rked nther than ent, the Medica	BeC	Hezekiah Clark			Brecke		
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once		Gilbert P. Dodd, JrSon	504 W. Laf	*			
of Heal		1 Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of o crematory or other place)		Date	20c. Location - City or	
Page ment o		4 Donation 5 Other Specify:	reenmount Cem	etery 12/	22/2011	Baltimore,	MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked nither th injury or other traumatic event, the Med		21. Signature of Funeral Service Licensee	22. Name and Addre	, IAI		/H East ll	Ol E. North
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/Medical		failure. List only one cause on each line.		g, coort ac caraiac or	oophatory arrot	or, or our, or recurr	Between Onset and Death
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	i	if any, leading to immediate Due to (or as a consequence or cause. Enter Underlying Cause	rf):				
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Division of Vital Records, P.O. Box 68760, To the Haspital or Attending Physician: The law requires that the death certificate be within 24 hours after death. The the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring	Certification:	4 Homicide determined (Specify)					
To the Has within 24 h Ta the Fur completely		29a Certifier (Check only one) Certifying Physician: To the best of my knowledge one) Medical Examiner: On the basis of examination a	ge, death occurred at the time,	date and place, and o	lue to the cause	(s) and manner as state	ed.
To ti withi To ti comp	Medical	one) 2 Medical Examiner: Or he basis of examination a and manner stated. 29b. Signature and title of certifier		nse number		29d. Date signed (Mor	
0 /	-			M.E.		December 19, 20	
1) \		30. Name and address of person who completed cause of death (Item					
OCME		Mary G. Ripple MD. Deputy Chief Medical Exar		re Street, Baltim	ore, MD 212	223	
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	farked	·			
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

		Please Type or Prin	nt in Black li	ndelible Ink. I	Ensure All Copies	s Are Legible.			
		a FOI	aryland / Dep	artment of Hea	alth and Mental Hy	giene			
		State Registrar	Cei	rtificate of Dea	ath	Reg. No. 2011 1012			
Physicia Medic		1. Decedent's Name (First, Middle, Last) Clarence P. Cowan			2. Date of Dea Month	ath Day Year 7, 3. Time of Death 7, 3.5 PM			
Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc	ation of Death	4c. County of Death			
Funeral			(In yrs. last birthday)		Under 24 Hrs. 8. Date of Birt	th 9. Birthplace (State or Foreign			
Director		248-34-1067 Usual Residence of Decedent	85 Yrs.	Months Days H	ours Min. May 22	2,1926 SC			
yland -f shov ed at	ctor	10a. State 10b. County MD Baltimore	10c. City, Town or Lo		Director	10d. Inside City Limits			
the Ma or 28a e notif	Director	10e. Street and Number		Middle 10f. Zip Code	KIVEL	1 ☐ Yes 2 ☐ No 10g. Citizen of What Country?			
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Should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M	2	James H. Cowan		10.	Irene E. Sa	· ·			
nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Heatil and Mental Hygiene. artiment of Heatil and Mental Hygiene. artiment of Heatil and Mental Hygiene. injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic.		19a. Informant's Name/Relationship (Type, Print) Randall P. Cowan /son		-		er, City or Town, State, Zip Code) Dre MD 21220			
permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State	20h Place of Dispo	sition (Name of	Date tery 12/24/1	20c Location - City or Town State			
mit. Pag bartmen sortant: r injury 2e.		4 Donation 5 Other (Specify) 21. Signature Juperal Service				1 BAltimore MD Ave. Balto. MD			
an per		I fold for cornelly	/ //	Connelly	Funeral Hom	ne of Essex 21221			
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are be executed hysician and the burial-transit	lical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):	3,					
requires that the death certificate be been signed by the attending physic should be detached for use as the bi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of the past 12 months? 4 ☐ Pregnant at the past 12 months?	2 🗌 Fetal death 3	Ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year			
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ath. : After e funer	icate	27. Manner of Death 1 Natural 5 Pending (Month, Day, 2 Accident Investigation		work?	28d. Describe h	now injury occurred			
io the frospital or Atending Prysician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.	ry - At home, farm, str (Specify)	eet, factory, office	28f. Location (S City or Tow	Street and Number or Rural Route Number, vn, State)			
Hospita 24 hours Funeral stely filled	Medical		amination and/or inves	tigation, in my opinion, d	eath occurred at the time, date a	and place, and due to the cause(s) and manner stated.			
Io the within 2 To the comple	Š	29b. Signature and title of certifier	best of my knowledge	29c. License nur		29d. Date signed (Month, Day, Year)			
	E 5, 11.75	150% MU	, 	Resc	0000	12-20 2011			
Stat	6	30. Name and address of person who completed cause of de St. Canada Port Port St. Canada Port Port St. Canada Port Port Port Port Port Port Port Port			are Drive B	altimore 4D 21237			
Registra		DEC 2 2 2011 Person	A. par	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 25 State of Mandand/Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 15ay 20⁴1 1:15 Ам Lorraine Diane Callicott Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Havre de Grace Harford Memorial Hospital Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday, If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Aug 16, 1950 Min. 1 🗆 M 2 💢 F Massachusetts Director 010-44-6108 60 Usual Residence of Decedent "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Havre de Grace 1 Yes 2 No MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 USA 116 Wilson St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 Married þ 8/15/1/Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: Yes. Give 3 Widowed 4 Divorced Completed Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natu jury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Un (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) school bus driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 은 Lauriel Callicott Phyllis Morrone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Wilson St; Havre de Grace, MD 21078 Carol Salamanca - friend 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛣 Other (Specify) in state cemetery, crematory or other place) 21. Signatur of Funeral Savice Licensee 22. Name and Address of Facility State Anatomy Board rector 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to force a cause of a caus Interval Between Onset and Death Physician/ Medical Due to (or as a consequ DI APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examine Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICAT IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? ملاولي Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Monatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation M 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Control of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAVRE de GRACE MO 21078 DAUM, MD 31. Date filed (Month; Day, Year) Registrar's Signature State 9 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OL'SOPM WENDELL CHANDLER 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMORE HARBOR HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Country) Maryland 1 K M 2 🗆 F Days Hours 0771911952 215 64 7932 Director 59 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Anne Arundel Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 440 Church Street 21225 U.S. or items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced White Completed Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Attendant Bob Bell Ford Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unknown) Chandler (unknown) Irene permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic v traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Chandler / Wife 440 Church Street Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 T Cremation 3 Removal from State 12/21/2011 4 Donation 5 Other (Specify) Baltimore, Maryland Bayview Crematory 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway nomera 23a, art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ~ aweeks CEREBRAL NASCULAR ACIDENT ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 2 WEEKS PNEUMONIA Sequentially list conditions, Examine cause. Enter Underlying and I-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 2 No been signed by the should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy s certificate ha 1 🗌 Yes 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No 1 🗆 Yes ဂ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After in motested filled in by the funeral (Month, Day, Year) 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No. Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the F
complet only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 172410 12/18/ 2011 Kuciono Vlugo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21225 BALTIMORE, MD VEIGA 3001 S. HANGUER ST LUCIANA 31. Date filed (Month, Day, Year)

OHMH 17 Rev 7/2009

State

Registrar

DEC 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	State of Maryland / Depa		1ental Hygiene	
			- Registral	tificate of Death	Reg. No. 2	011 41045
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		Date of Death Month Day	Year 3. Time of Death
	Medic	cal	Condition Colladar		12 40	
	Examin	ier	4a. Faulity Name (if not institution, give street and number)	4b. City, Town, or Location of Death Fort Washingtor		nty of Death
er och der	Funeral		8406 Driftwood Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
	Director		224-08-9813 1 ₺ M 2 □ F 53 Yrs.	Months Days Hours Min.	(Month, Day, Year) 06/13/1958	Pennsylvania
	d ow	,	Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Loc			10d. Inside City Limits
	ryland -f sh ied at	cto				1 🛣 Yes 2 🗆 No
	r 28a notif	Director	MD Prince Georges Fort Was	nington 10f. Zip Code	10g Citizen	of What Country?
	/ith th	ral		20744	U.S	
	death with the Maryland ritems 23a or 28a-f sho ner must be notified at	Funeral		Vas Decedent of Hispanic Origin? (Spe	cify Yes or No-	Race - American Indian,
٥	ter de	by F	1 X Never Married 2 Married 1 Yes 2 No	f Yes, specify Cuban, Mexican, Puerto □ Yes 2 🛣 No Specify:		Black, White, etc.
9500-6121	72 hours after n "natural", or Aedical Exami	ted	3 ☐ Widowed 4 ☐ Divorced Year or Dates.		Spec	wnite
င် င	72 ho "na" r	Completed	(Specify only highest grade completed)	lent's Usual Occupation kind of work done during most of worki O NOT use retired)	ng 16b. Kind of	f Business Industry
717	/ithin iene. r thau the N	ပြ	Elementary/Seconday (0-12) College (1-4 or 5+)	presentative	Serv	ice Revenue
Maryland 2	I be filed within 72 hours after death with the Maryland fental Hygiene. rked other than "natural", or items 23a or 28a-f show rice event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Surna	ame)
Mai	ld be Menta arkec artic e	욘	William James Callaghan	Louise		ovich
Jar	1 and 2 should be file f Health and Mental item 27 is marked o other traumatic eve			ng Address (Street and Number or Rura		
ď	and 2		Louise Mary Callaghan/Mother 8406 20a. Method of Disposition 20b. Place of Dispo	Driftwood Lane, F		on - City or Town, State
baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		1 Burial 2 Cremation 3 Removal from State cemetery, crem	natory or other place)	1	
	artme artme ortani injury		4 ☑ Donation 5 ☐ Other (Specify) Anatomy G. 21. Signature of Emeral Service Liousee 22	ifts Registry 12/20 2. Name and Address of Facility And	U/ZUII Hanov	er, Marylanu Pegistry
n	permit Depar Impor any in			522 Connelley Dr.		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter			Approximate Interval Between
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	Medical Examiner		resulting in death) a. Due to (or = a consequence of):	A C TALL TO THE		
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٥ ×	th cer ttendi	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3			Date of delivery Month Day Year
20	the a	ysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)		
л Э	hat th ed by detac		Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did tobacco use co	ontribute to the cause of death?
Ś.	n sign	ed by	Seizure augustu		1 ☐ Yes 2 🗷 N	lo 3 🗆 Probably 4 🗆 Unknown
Vital Records,	w req	Completed			24a. Was an autopsy	4b. Were autopsy findings available prior to completion of cause of
9	The la	E O			performed?	death? 1 Yes 2 No
g	ian: T	Bec	25. Was case referred to medical examiner?	26. Place of Death (Check		
5	hysic this ce	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier		ome 5 Residence 6 0	
10 L	ling F J. After 1 funera	ate	27. Manner of Death 1 ✓ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	28d. Describe how injury occ	curred
SIO	deatl deatl ctor: y the	Certificate:	3 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 128e. Place of Injury - At home, farm, str		28f. Location (Street and Nu	mber or Rural Route Number,
DIVISION	al or / s after il Dire		4 Homicide determined building, etc. (Specify)		City or Town, State)	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investigation)	occured at the time, date and place, ar	nd due to the cause(s) and ma	anner as stated.
	the P thin 24 the F mplet	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	death occurred at the time, date and place	ce, and due to the cause(s) and	d manner as stated.
	5 ≥ 6 8		29b. Signature and fitte of certifier	29c. License number 26434	29d. Date sig	gned (Modth, Day, Year)
			30. Name and address of person who completed cause cleath (Item 23a) (Type, F	Print\		-
			HOME PHEICIANG FOR DIGHTALD	Prof CINTHICUR	1 M) 21	090
	Sta Registr		31. Date filed (Month, Day, Year) UEC 2 2 2011 32. Refisher's Signature	Land		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4b. City Town, or Location of Death 4c. County of Death **Examiner** Alti UhBING If Under 1 Year | If Under 24 Hrs 8. Date of Birth . Age (In vrs. last birthday) **Funeral** 219-40-0885 1 XX 2 □ F Months Days Hours Min 67 1/29 th 87 1 943 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4514 Bayonne Ave 21206 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 △ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 XX No Specify: Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Monotype Composition traumatic event, the Typesetter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Munchalk ဂ္ Chencharick Anna Andrew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 21206 Christopher Chencharick (son) 4514 Bayonne Ave., Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Beulah Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/19/2011 Ramey, PA 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. e of Funeral Service Licensee 6415 Belair Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami and Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 No ed by the a detached f q Unknown 9 Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe Physician: The Yes Division of Vital Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending I (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) State

n/a

9. Birthplace (State or Foreign

10d. Inside City Limits

White

21206

Approximate Interval Between

Onset and Death

Year

Day

1 ☐ Yes 2 ☐ No

1 Yes 2 □ No

CouMaryland

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** OZSOAM 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AGNES HOSPITAL SALTIMORIE If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last, birthday) **Funeral** 1□M 2□F Months Hours -22 Days Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mydical Exact har must be routified at 1 Pes 2 □ No **Funeral Director** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 01229 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospita 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ole ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Belationship (Type. Print) Pages 1 and 2 si ment of Health an Health a tem 27 is 21229 Balto. mo 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If it any Injury or o I Burial 2 ☐ Cremation 3 ☐ Removal from State ansdowne, mo 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Juneral Service Liceration 22. Name and Address of Facility Balto MD 23a. Part VENEZ he Wease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line.

Immediate Conse (Final disease or condition) Approximate Interval Between Onset and Death **Physician** 3 DAYS disease or condition resulting in death) HEART Frunc CONGESTIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) his certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown KIDNEY DISERSE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P2407C Merria 19

State Registrar HOSPIT

900

S. CATON

AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGNES

SANGITA VERMA

31. Date filed (Month, Pa), Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 1200 AM 201 2 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA Care Baltimore Nursing Home If Under 1 Year If Under 24 Hrs. Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 251-42-576 Hours 1 ☐ M 2 💢 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, "In Medical Examinations to nother profiled at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □No Baltimore Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Daniels aniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Ford Estates Balto, MD Vaniels-Grandson 5507 ermaine 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Burial 2 Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) (Conefory 1/42/2011 Daltimore, MU 22. Name and Address of Facility March F/H East 1101 E. North 21. Signature of Funeral Service Licensee gnette Ave. Baltimore, MU_21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examiner Due to (or as a consequence of): to the Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No page 2 should be detached for Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 2 🗆 No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2[]No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ ₩6 Director: After this I in by the funeral di 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 🗌 Pending 1 ☐ Yes investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel I t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) . 283 31. Date filed 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 41049 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18. 2011 11:38 AM Betty Elaine Doran December Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Hours Min. 214-24-3884 **Director** 1 M 2 XF 83 Apr. 13, 1928 Maryland Usual Residence of Decede 28a-f show 10a. State 10b. County 10d. Inside City Limits at 10c. City, Town or Location with the Maryland Director notified 1 Yes 2 XNo Maryland Harford Joppa 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 2302 Dunwood Lane 21085 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ŏ by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: "natural", White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Health and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Income Tax Company Accountant Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ other traumatic Maurice Josef Roth Lillian Elizabeth Hackett 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other tractore. John L. Doran / Husband 2302 Dunwood Lane, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Hilltop Service Corp. 12-21-2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Imo nary diseas Chrone Obstructive Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) ×16 days Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical the death certificate be ast IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Day Pregnant at time of death 1 Urknowi Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes No 1 Yes 2 No **Division of Vital** or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: **⊅**Q No 1 🗌 Yes မ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours a To the Funeral C completely filled Hospital Medical K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number December 18,2011 Medical doctor D71096 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) ANGELITA ESTADILLA SE Upper Chesapeala pr. Bel Air MD 21014 31. Date filed (Month Day Year) ... 32.

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Cer	tificate of Death	Reg. No.	1 4103							
Physical Exar	cian <i>i</i>	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year December 7, 2011	3. Time of Death 1659 hrs							
Sulcai Exai	mne	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death									
		Good Samaritan Hospital	Baltimore	N/A								
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min									
Directo	2[218-02-8423 1 M 2KF 43	Yrs.	Dec. 6,1968 Maa	owland							
any		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits							
*	g 5	Maryland N/A Ba	ltimore		1X Yes 2 No							
Maryli 28a-f	al Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	ntry?							
ith the	ral Di		21206	USA								
eath w	ner	1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 		ican Indian, Black,							
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hin 72 e. than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 11th grade	Cashier	7-11 Conver	nience Store							
5-0036 led within 7. Hygiene.		17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)								
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f sho	8	William Edmonds Bertha Harlee										
MD 2 d 2 shoul lth and N	ို	Alonzo Harlee	4235 Sheldon Avenue Ba	Rural Route Number, City or Town, State altimore, Maryland	, Zip Code) 21 206							
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Baltimore, permit. Pages I a Department of He Important: If the injury or other in		The pariety of the pa		20/11 Dundalk,Mar	y.land							
Salti ermit. Separtn mport.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Chat	tman-Harris Funera	l Home							
Physician		23a. Part I. Enter the disease, or complications that caused the death.		attimore, rary tand	21215 Approximate Interval							
/Medica	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Complications of Methac		Troopiratory arrost, stroot, or mail	Between Onset and Death							
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Division of Vital Records, P.O. Box 68760, To the Hopptal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	₽	F FEMALE: 23c. If yes, outcome of pregn 23b. Was decedent pregnant in the		23d. Date of delivery								
Box 687 e death certific the attending	Physician	past 12 months? 4 Pregnant at time of dea	2 Fetal death 3 Ectopic pregna ith 5 Other (Specify)	ncy Month E	Day Year							
BO)	ع ا	1 Yes 2 No 9 Unknown 9 Unknown										
P.O. ss that the gned by e detache	Ę.	Part II. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to 1 Yes 2 ✓ No 3 Prob								
ords, P.C. Iw requires that as been signed 1 2 should be deta	je Pe	Diabetes, Obesity			topsy findings available							
e law re has b	Completed			autopsy prior to comperformed? death?	ompletion of cause of							
I Re II: The rtificate or, page	ြင္သ	25. Was case referred to medical	26.Place of Death (Check of	1 Yes 2 No 1 Ye	s 2 No							
Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 I		g Home 5 Residence 6 Other	:							
ing Ph After After funeral		27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 3 No.	28d. Describe how injury occurred Subject took drugs								
Sior Attend death. ector:		2 Accident Investigation Dec 5, 2011	0000 hrs		15							
Division pital or Attentours after death reral Director: filled in by the	1	determined (Specify) Circle Cons	me, farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State) 30 South Fulton Ave. #1, Baltimore								
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	`	4 Homicide Single Fam. 29a Certifier 1 Certifying Physician: To the best of my knowledge.										
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination an and manner stated.	d/or investigation, in my opinion, death occurred a	t the time, date and place, and due to the	e cause(s)							
	ž	29h Signature and title of certifier	29c. License number	29d. Date signed (Mor								
4		Och Hiller Weed	O.C.M.E.	December 10, 20)11							
ラ レ	1	 Name and address of person who completed cause of death (Item 2 Victor Weedn MD JD Assistant Medical Examine 	^{23a)} er = 900 W. Baltimore Street, Baltimor	re, MD 21223								
	State	The State of the S										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/lichael E. Epp	s, JF	Sta 1-For State Registrar	ate of Maryla		artment of rtificate of		nd Ment	al Hyg		g. No.		4105
Physic Medical Exam		Decedent's Name (First, Middle	e,Last) Zekiel	Epps	, Jr.				Date of Death Month December	h		Time of Death 1939 hrs
		4a. Facility Name (if not institution Prince Georges Hospit		mber)		4b. City, Town, Cheverly	or Location o			4c. County o		
Funeral Director		5. Social Security Number 578–21–6146	6. Sex	7. Age (In yrs. I	last birthday) Yrs	If Under 1 Y Months D		Min.	8. Date of Birt	h(MM/DD/YYYY) /1991	Foreign	olace (State or try) DC
nd show any ice.	_	Usual Residence of Decedent 10a. State 10b. County MD Balti			Town or Locat				,		- 1	Od. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once,	Director	10e. Street and Number 7405 Brixworth				10f. Zip Code 21244			10	g. Citizen of Wh	at Country	y?
after death wi	y Funera		rried Armed Fo	2 X No	If Y	s Decedent of I es, specify Cub Yes 2 X	an, Mexican,	Puerto Ri	can, etc.)	White Specify: I	, etc. 31.ack	
7 3 7	Completed	15. Decedent's Education (Specific Elementary/Secondary (0-12)	ify only highest grad			t's Usual Occup ost of working I .oyed				16b. Kind of Bus	siness/Ind	lustry
	To Be Cor	17. Father's Name (First, Middle, Michael Epps, S 19a. Informant's Name/Relationsh	r.		19b. Mailing	g Address (Str	Rhono	la Ep	ps	laiden Surname) ber, City or Towr	ı, State, Z	(ip Code)
9, MD and 2 sh fealth and item 27 is		Rhonda Epps/Mo 20a. Method of Disposition 1 Burial 2 Cremation			7405 Place of Dispos crematory or oth	ition (Name of			204 Ba	1timore		
Baltimore permit. Pages 1: Department of Ht Important: If it injury or other t		4 Donation 5 Other Sp 21 Signature of Funeral Service	ecify:		22. N	lame and Addre	ss of Facility	Marsh	nall-Ma	Riverda rch Fun n, DC 2	eral	
Physician	8 8	234 Part I Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. Multiple Gu Due to (or as a	nshot Wour	nds	ne mode of dyir	g, such as ca	rdiac or re	espiratory arre	est, shock, or hea	rt	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and rompletely filled in by the funeral director, page 2 should be deached for use as the burial—transparence of the control	Physician/Me	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk	1 Live bi	ant at time of de	2 Fe	tal death Sher (Specify)	B Ectopic	pregnanc	у	23d. Date of o	delivery Day	y Year
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n of Vital Reco ding Physician: The law h. After this certificate has funeral director, page 2 si	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatient	3 DOA	Other at Work?	Nursing F	Home 5 F	Residence 6 ow injury occurre	ed	
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should b	Certification:	3 Suicide 6 Could	not be 28e. Place		1856 hrs ome, farm, stree		Yes 2	No 28	Bf. Location (S or Town, St		r or Rural	Route Number, City
o the Hosp ithin 24 ho o the Fune	Medical C	29a. Certifier 1 CertifyIng Ph	ysician: To the bes niner:On the basis of and manner st	of examination a								
• • • • •	Me	29b. Signature and title of certifier Pumuk Byruhau	(ml)				nse number C.M.E.			29d. Date signe		
		30. Name and address of person Pamela E. Southall, M	D Assistant I	Medical Exa	miner 900) W. Baltimo	ore Street,	Baltime	ore, MD 21	223		
S	tate	31. Date filed (Month, Day, Year)		gistrar's Signati	ure L	Lead .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18,2011 Physician/ Month Ebersole Francis Herbert 2:40 P M Medical December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7915 Diehlwood Road Dundalk If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 18,1928 Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Min 1 🙀 M 2 🗆 F Days Hours Pennsvlvania Director 165-24-6085 83 Usual Residence of Decedent show 10a, State 10h. County at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f 1 Yes 2 X No MD Dundalk Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 21222 7915 Diehlwood Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deau Department of Health and Mental Hygiene.
Important: If item 27 is marked other transmitting or other transmitted. Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married 1 Yes 2K No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry 12 Years 4 Years Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ann Marie Mickel David Blair Ebersole, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21090 Craig M. Ebersole 6200 Chestnut Oak Lane Linthicum, MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of ☐ Burial 2 😿 Cremation 3 ☐ Removal from State Hilltop Service Corp. 12/23/2011 Towson, Maryland 4 Donation 5 Other (Specify) Signature ²² Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Wise Ave. Dundalk, Maryland Approximate Interva, B. tween ath 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardino or respiratory arrest shock, or heart failure. List only one cause of peach line. Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 1 Probably 4 ☐ Unknown Completed should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Yes 2 this certificate 1 Tes 2 🗌 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Man or of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie 29d. Date signed (Month 29c. License number Day, Year, Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $7:45p_{M}$ Physician/ Dec. 1⁹9 2 0°911 Loretta E. Flashell Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis Heritage Center Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Days 1 □ M 2**X** F Hours Country) \$\tensorman, 2\tensorman, 191 4 212-28-9622 97 MD Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Baltimore MD Essex 1 🗌 Yes 2 🍱 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 808 North Woodlynn Road 21221 USA Funeral "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3X Widowed 4 ☐ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Madic once. (Give kind of work done during most of working life. DO NOT use retired)

HOmemaker (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) August Schlereth Mary Koch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Szczechowiak /daughter 808 North Woodlynn Road Balto. MD 2122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Parkwood Cemetery 12/23/201 Baltimore MD 4 Domation 5 Other (Specify) . Sign xure of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD attick Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. "SCLEROTIC CARDIO VASCULAR DISTAND Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregna Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months' 1 Yes 2 No ed by the a Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to by 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an Jas page 2 death? perform To the Hospital or Attending Physician; The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to edical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Watural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier rppleted dause of death (Item 23a) (Type, Print) 10 410

Registrar

State

31. Date filed (Month, Day, Year)

2 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ハルフハ pecembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OSpital remunai HMUSE 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months Days (Month, Day, Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23° --- any injury or other traumatic event, the Madical Conference once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Live.
Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 'A rdner altimore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden မ Oh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimor MMA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kandallstown, MID 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H East 1101 E. North Ave. Balto MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pnysician/ A Cuth 00 20 min disease or condition Medical resulting in death) Due to or as a consequence of): **Examiner** yeary ormany Faculations list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and dedetached for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has page 2 autopsy performed' 2 ANO completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 40 Hospital: Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28c. Injury at 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗔 within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) amara 52016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21218 Forst 31 amour

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day,

Registrar's Signat

DHMH 17 Rev 06-2011

State Registrar TRACIE L.

2 2 2011

TIMONIUM, MD 21093

MORGAN, CRNP 2300 DULANEY VALLEY RD.

32. Registrar's Signatu

11-09510 Stephen Field

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		icate of Death	Reg. No.	1 4105
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year December 18, 2011	3. Time of Death
	4a. Facility Name (if not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore		h
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last b	oirthday) If Under 1 Year If Under 24Hr	s. 8. Date of Birth (MM/DD/YYYY) 9. Bi	an .
Director	218-62-2724 11XX M 2 F 58	Yrs. Months Days Hours Mir	April 8, 1953	puntry) MD
ow any		vn or Location Baltimore		10d. Inside City Limits 1 XX Yes 2 No
the Maryland a or 28a-f sho tified at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	
eath with the Maryland items 23a or 28a-f sho ust be notified at once ineral Director	2918 Huntingdon Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	21211 13. Was Decedent of Hispanic Origin? (S	U.S.A.	ican Indian, Black,
0036 within 72 hours after death with the Maryland piene. For than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once ompleted by Funeral Director	1 Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	
nours after a latural" Laminer 9d by	3 Widowed 4 Divorced of Dates: 15. Decedent's Education (Specify only highest grade completed) 16a	a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done 16b. Kind of Businessi	
5-0036 ted within 72 hours Hygiene. there than "nature the Medical Exami	Elementary/Secondary (0-12) College (1-4 or 5+)	N/A	N/A	
P 2 2 4 7 0	17. Father's Name (First, Middle, Last) Edward J. Field	18.Mother's Name Mary J.	(First, Middle, Maiden Surname)	
Should be fill and Mental It is marked natic event.		19b. Mailing Address (Street and Number or 2918 Huntingdon Avenue B	Rural Route Number, City or Town, State	a, Zip Code)
■ Part and a market	20a. Method of Disposition 20b. Place	e of Disposition (Name of cemetery,	Date 20c. Location - City or	Town, State
Baltimore, permit Pages I an Department of He Important: If ite injury or other trees.	4 Donation 5 Other Specify:		22/2011 Glen Burnie	•
Balti permit. Departi Import injury	21. Signature of Funeral Service Actionsee	22. Name and Address of Facility Burg 3631 Falls Road Balt8		Home, Inc.
Physician /Medical	23a. Part 1. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):	Cardiovascular Disea	se	
iner	Sequentially list conditions, if any, leading to immediate course Enter Underlying Course			
ted nsit Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
60, ate be execur hysician and te burial - tra Medical	M UNPENDED AMENDED 23a, pt.II,	27,per me,g923 1-20-	I2 sm	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnance 1 Live birth	cy 2 Fetal death 3 Ectopic pregna	23d. Date of deliver ancy Month	y Day Year
). Box 687 the death certific by the attending p ched for use as th	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 9 Unknown	5 Other (Specify)		
i, P.O. lires that the signed by the detached by PP	Part II. Other significant conditions contributing to death but not result Chronic alcohol Use	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
Division of Vital Records, P.O. Ial or Attending Physician: The law requires that it is after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactor, page 2 should be detactor. To Be Completed by F.	GRIONIC arconor esc		24a. Was an 24b. Were au	utopsy findings available
tal Recc			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	
Vital Rechysician: The this certificate I director, page	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/	26.Place of Death (Check Outpatient 3 DOA Other Nursin	only one) ng Home 5 Residence 6 Othe	r.
ion of tending Pheath.	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b	D. Time of Injury 28c, Injury at Work?	28d. Describe how injury occurred	
Division (spital or Attending tours after death. noral Director: Af filled in by the fun Certification	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State)	ıral Route Number, City
Division To the Hospital or Attention within 24 hours after death To the Fuorral Director: completely filled in by the	4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	leath occurred at the time, date and place, and		ed.
To the Bowithin 24 To the Fu completed	one) 2 Medical Examiner: On the basis of examination and/o and manner stated. 29b Signature and title of certifier.			e cause(s)
	Teta Voto Teld nost	O.C.M.E.	December 19, 20	
	30. Name and address of person who completed cause of death (Item 23a Victor Weedn MD JD	900 W. Baltimore Street, Baltimo	re, MD 21223	
State Registrar	31. Date filed (Month, Day, Year) 72. Registrar's Signature	barles		

OCME

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			State of Maryland / Department of Health and I 1- State Registrar State of Maryland / Department of Health and I Certificate of Death		71111	41057
			1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Reg. Nd	3. Time of Death
	Physici		Stooler 1 Fields	Month	Day Year	1:58 AM
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Deat	h
	ZX		(munity Specially Hospital Baltimore 1	nd		nore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Min.	(Month, Da	h y, Year) 9. Birt Co	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	09/13	11943 M	ary land
	land wo		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Many a-f sh	tor	MD NA Baltimore			1 XYes 2 No
	th the or 284	Olrec	10e. Street and Number #55 10f. Zip Code		10g. Citizen of What Co	untry?
	ath w	Funeral Director	1510 N. Mosher Street Apt. 21217		USA	
	er de:	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No o Rican, etc.)	- 14. Race - Ame Black, White	ncan Indian. ^{9, etc.} African
36	irs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify: Year or Dates:		Specify: Ame	
ŏ	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	rkina	16b. Kind of Business/	Industry
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2	led w lygier her th		12th Grade NA Truck Driver		Middleton Maiden Sumame)	& Mead
and	should be filled within 72 hours after death with the Maryland nod Mental Hygiene. In a Maryland in Marked other than "natural", or items 23a or 28a-f show umatic event, the Maryldal Expiritor must be notified at	Be				
2	should od Me mark matic	2	Wilford Fields Mildre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru		Davenpo ar, City or Town, State, 2	
2	and 2 s ealth ar n 27 is ser treu		Tara Fields-Daughter 1017 N. Woodington		-	
9	s 1 a of Hea item item		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or	Town, State
<u> </u>	Pages nent of the ant: thite ury or of			19-11	Catonsvi	lle, MD
Baltimore. Marvland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Vylie F	uneral Ho	me P.A.
	20 E # 9		Surela Surgoton 638 N. Gilmor S			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between Onset and Death
34	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)			
	Examiner		Due to (or as a consequence of):			
		Jer	Sequentially list conditions, it any, leading to knowledge and cause. Enter Underlying Cause (Disease or injury) ACAL AMADA AND ACAL AMADA A			
	te be executed ysician and se burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
760,	oe execian a		Cause (Disease or injury that initiated events resulting in death) Last c. ACAC AMOS with perforting Due to (or as a consequence of): d. Human Immondation for the perforting of the perforting of the performance of the pe	/		
87	cate t	dlcal	d. Human Immunoacticias fine	noon		
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B	that the death cer ed by the attendir detached for use	Physiclan/Medl	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
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e C	has by	Completed by	Amenia, Kyphaiu,	24a. Was auto	an 24b. Were at prior to death?	utopsy findings available completion of cause of
E H	r. The		Centrilis Intected Au GUEFL	1 ☐ Yes	2 No 1 ☐ Yes	2 No
N. S.	hysician: The la his certificate ha I director, page 2	o Be	examiner?	ath (Check only o	dence 6 other (Spe	mile i TMC
o	ding Phy h. After this funeral d	n: To	27. Many r of Death 28a. Date of Injury 28b. Time of 28c. Injury at	,	how injury occurred	LIAC
ion	ath. r: Afte	atio	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division of Vital Records, P.O. Box 68	I or Attendatter deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To	Street and Number or R wn, State)	ural Route Number,
Q	urs af eral D			,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)			
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon.	th, Day, Year)
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1			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		0 11	1
1) _	= 1		Eric A. R. How MD GUI JOUTH Charles	JK. 1	Geltemore	M 2120
	StaRegistr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Agarket			
W D	HMH 17 Rev 1/2		DEC & & Lott			
1.				,		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BARBARA REEMAN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 2405 Presbury Street NA Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8 Date of Birth **Funeral** Days 218-28-8200 Hours (Month Day, Year) 04-04-33 78 1 🗆 M 2 🗗 F **Director** Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director XXYes 2 No MD NA Baltimore 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 2405 Presbury Street 23a 21216 USA items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American India Medical Examiner Black, White, etc. African ō þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify. Specify: American 'natural" Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker 8th Grade NA Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked or ပ္ Hopkins Elizabeth Moses Settle traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau 123 W. 29th Street Apt.3L Baltimore, MD. Muriel Freeman-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Owings Mills, MD Garrison Forest 1-04-12 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wlie Funeral Home P.A. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 ☐ Yes 2 XNo funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\to \) Nursing Home 3 \(\to \) Residence 6 \(\to \) Other (Specify) 2 No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🕊 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifie

address of person who con

2011 2

leted cause of death (Item 23a) (Type.

			For State Registrar	riease	State of		nd / Dep		t of H	ealth a	and M	ental Hy		2011		41059
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	/Medic	al	4a. Facility Name (If not	institution ai			116	4h City	Town or	Location of	of Death	Deceml		17, 201		11:00 A
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	Funeral		5. Social Security Numb		Sex		. last birthday	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	th v, Year			e (State or Foreign
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336	s 1 end 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "naturel", or iteme 23a or 28e-f ehow other traumatic event, the Madical Examinational Carolified at	þ	1 Never Married 3 4 Widowed 4		Armed For 1 ☐ Yes If Yes, Gi	2 XNo ve		1 Yes, spec		n, Mexicar Specify:		Hican, etc.)		Black, Wh Specify:	Whi	
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Maryland	2 sho and ! is ma		19a. Informant's Name											or Town, State		
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Baltimore,	permit. Pages 1 en Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposit 1 Burial 2 C 4 Donation 5	emation 3 (State G1	Place of Disp cemetery, cre en Have	en Men	ı. Pa	rk 1	2/21	/2011	G1e	n Burni	ie,	Maryland
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,09	Physician /Medical Examiner portional functions of the properties	cal Examiner	23a. Part1. Enter the dishock, or heart fall Immediate Cause (Find disease or condition resulting in death) Sequentially list condition fany, leading to immediate. Enter Underlyin Cause (Disease or injust that initiated events resulting in death) Last	lure. List onh	a. Due to	each line	equence of): MS 5M equence of):			-		or respiratory a	rrest,		lr C	oproximate niterval Between hiset and Death
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	uires that the de n signed by the e id be detached f	y Ph	Part II. Other significar	t conditions	contributing to c	leath but not re	esulting in the	underlying o	ause give	en in Part I	1.	23e. Did 1	obacco	use contribute	to the	cause of death?
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	To the Hospitel or Attending Physician: The lev within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Certification:	29a. Certifier 19 (Check only one)	Certifying F Medical Exa	Physician: To the temperature of temperature of temperature of temperature of temperature of temperature of	e best of my k	nowledge, dea nation and/or in	th occurred nvestigation	at the tin , in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause((s) and manner and place, and c	as stat	ted. he cause(s)
	To th within To th compl	Me	29b. Signature and title Attached 30. Name and address 31. Date filed (Month, C	of certifier	gang 9 Pl	elv 4	ah	290	. Licenso	a number	973		29d. D	Date signed (Mo		
L			30. Name and address	of person, who	completed cau	se of death (It	em 23a) (Type	Print) URN	16,	Md	, 2	1061				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ PM Albertha Grissette 2 December 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Good Samaritan Nursing Center Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Hours S.Carolina 219-40-6238 **Director** 7,1934 March Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director N/A MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5933 St. Regis Road 21206 USA 72 hours after death 12, Was Decedent Ever in U.S. Armed Forces? 1 Yes ZANo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Specify: Black Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 6th Grade Own Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Eloise Parson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lila Nole/ Daughter 5933 St. Regis Road Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 12/17/11 Windsor Mill, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. oximate erval Betweer shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Directo for as a consection of Examir Hospital or Attending Physician; The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 4 Pregnant a Pregnant at time of death 5 Other (specify) detached 9 Unknown by Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. peu 23e. Did tobacco use contribute to the cause of death? þ s been signe should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas director, page 2 autopsy performed? certificate I 1 Yes 2 No Be 25. Was case referred to m al 26. Place of Death (Check only one) examiner? Hospital: Other: 4 A Nursing Home 5 Residence 6 Other (Specify) ပု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this completed filled in by the funeral 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending s after death 2 Accident Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 5601 Loch Ravon Blud Balti 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of F . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 20, 2011 6 PM Ida E. Grine Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Golden Living If Under 1 Year Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 🛛 F Days Hours 9/13/1918 93 Director MD 220-18-6216 Usual Residence of Decedent show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21157 1234 Washington Rd. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes. Give 3 Nidowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " Seconday (0-12) College (1-4 or 5+) Federal Employee NSA and Mental Hygien is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Frances Ford Louis A Curtis Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tratonce. 901 Lee Ave. Sykesville, MD 21784 Nancy Grothe (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 12/23/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory, P.A. 001 Old Liberty Rd. Winfield, MD 21784 1212 W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the I IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? ó Month Year Pregnant at time of death the 9 Unknown detached g 🔲 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

(Check only one

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Rosemary Virginia Gebhart December 2011 3:35 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours **Director** 212-42-0868 1 M 2 XF 1943 Maryland 68 Aug. 20, Usual Residence of Deceden 28a-f shov 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Abingdon 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 777 Burgh Westra Way 21009 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ō þ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government IRS Agent Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, it once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles (unk) Rollins Rosemary Virginia Church 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Ronald Gebhart / Husband 777 Burgh Westra Way, Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 X Cremation 3 Remova Hilltop Service Corp! 12-23-2011 Towson, Maryland onation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ LUNG CANCER disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Dav Year Month Pregnant at time of death 5 Other (specify) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗌 No 3 💢 Probably 4 🗎 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 s autopsy Hospital or Attending Physician: The this certificate **Division of Vital** director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After injury X Natural 5 Pending 2 No Accident 1 Yes Investigation within 24 hours after death

To the Funeral Director:,

completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Frecitioner: To the best of my investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) and manner stated Certifying Nurse Frecitioner: To the best of my investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) and manner stated (Check 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) on who completed cause of death (Item 23a) (Type, Print) 30. Name and add ess of 2300 DULANEY VALLEY RD. JONES, CRNP TIMONIUM, MD 21093 JACKIE

DHMH 17 Rev 06-2011

State

Registrar

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3:35

DECEMBER 19,

ROSEMARY GEBHARDT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 DECEMBER 11:30A **EVELYN** GREEN Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE 2310 SUGARCONE ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours Min 217-24-9099 Director 1 M 2 X F 85 06/07/1926 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2310 SUGARCONE ROAD 21209 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian er than "natural", or iter the Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 2 SACHS permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic JULIUS ADLER ELSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MORRIS GREEN / HUSBAND 2310 SUGARCONE ROAD, BALTIMORE, MD 21209 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CONG 12/22/2011 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir 100 use as the burial-transi 20 that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy funeral director, page 2 perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 🖾 p/ esidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury Natural Natural 2 🗀 No Accident Investigation completely filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

To the Vithin 2 To the F

State

DHMH 17 Rev 06-2011

29a. Certifier

29b. Signati

(Check

only one

3

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 201 Day Physician/ Dorothy Gibson Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death County of Death Baltimore Battimore Nursing and Overlea Kehab 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 F Months Hours (Month, Day, Year) Yrs Director 216-20-4832 84 February 3, 1927 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland 1 X Yes 2 No Baltimore Baltimore 2 should be filed within 72 hours a....
Ifth and Mental Hygiene.
127 is marked other than "natural", or items 23a or 28:
127 is marked other than "natural", or items 26 hot 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6802 Eastbrook Ave. 21224 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 x Married If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed Baltimore, Maryland 21215-00 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housewife 8 years Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Lasek Florence Barczak Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Gibson 8044 Main St. Ellicott City. Son Md. 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State December st. Stanislaus Cem. 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 23, 2011 Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. Sona ure of Fundral Service License 7110 Sollers Point Road, Dundalk Md. r complications that caused the death. only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. List not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Hematomo Physician/ ubdura disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 9 Fall day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying MEDICATION APPROVED BY MEDICA Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending house and attending the state of the funeral Director. -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 2 X No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be exammer? 1 X Yes Other: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ⚠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 12 11 2011 28c. Injury at work? 1 ☐ Yes 2 🔀 No Manner of Death 28b. Time of Medical Certificate: 1 Natural
2 Accident
3 Suitable 28d. Describe how injury occurred iniury 5 Pending Fell Z=00AM home Investigation completed filled in by the 28f. Location (Street and Number or Rural Route Number, MD 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 6802 E. Brook Ave. 1-tome 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Dec 20, 2011 WI D45757 MO ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Baltimore, MO 21224 4940 Eastern Ave MCNESNEW 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

Registrar

2 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State o	f Maryland	/ Depa	ırtmen tificate	t of H	ealth a eath	and M	ental H	ygiene Reg. No.		410	165
Physicia /Medic		1. Decedent's Name (First, Middle Anna Grime)	7						[2. Date of D Month	Day	Year 2011	3. Time of D	
Examin		4a. Facility Name (If not institution Johns Hopkins Bay	view Medic	al Center		Baltir	nore	Location o				County of Deat		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is merked other then "nature", or items 23a or 28e-f show a simple of the merked other than Medical Examiner must be notified at one.		5. Social Security Number 212-32-8689 Usual Residence of Decedent	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. las	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, L August	14,1	.935 Ma	hplace (State or F Intry) Tryland	oreign
	ctor	10a. State 10b. County		10c. City,	Town or Loc Ba	ation 1 tim c	re						10d. Inside City	
	Funeral Director	10e. Street and Number 3521 Elmley Ave	nile			10f. Zip-	Code	212	13		10g. Citiz	zen of What Co	untry?	
s after deaf or Items miner mu		11. Marital Status 1 ☐ Never Married 2← Marri	12. Was Dece	edent Ever in U.S. rces? 2 No e		Vas Deced f Yes, spec				cify Yes or N Rican, etc.)	0-	14. Race · Ame Black, White	e, etc.	
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s 1 and 2 f Health a ftem 27 is other trau		Vernon Grimes 20a. Method of Disposition			ce of Dispo	sition (Nan	ne of	- ;		Balt ate	_	. 21213		
nit. Page vartment o ortant: If i injury or e.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) 21. Signature of Funeral Service L	pecify)	Jidio	netery, cren dens 22		ith	1				o. Md.		
permi Depar Impor eny Ir	77	22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Road Nottingham, Md. 21236 23a. art 1. Enter the disease, or conjections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between												
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death Lung Handling Due to (or as a consequence of):												
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):												
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or Attending Physicien: after death. Director: After this certifics in by the funeral director.		27. Manner of Death 1 Natural 5 □ Pending investig	28b. Time of Injury	f 2	28c. injury at Work? 28d. Describe			be how injury occurred						
tal or Attending F rs after death. el Director: After t led in by the funer.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, c building, etc. (Specify)								City or T	own, State)	tural Route Numb	ier,
To the Hospital o within 24 hours af To the Funerel DI completely filled in	Medical	(check only 2 Medical one)		best of my knowl asis of examination ner stated.	edge, death on and/or inv	vestigation	, in my op	pinion, de	nd place, a ath occurr	and due to to	ne, date an	d place, and du	ue to the cause(s)	ļ
Mith To D	2	29b. Signature and title of certifier		MD		1	License				1	mber 1		
Íν		30. Name and address of person Shown By ad 21. Data filed (March Day York)			_	,		49	940 Ea	astern /	Avenu	e, Baltim	ore, MD, 2	21224
Sta Registr		31. Date filed (Month, Day, Year) DEC 2 2 2011	Denver	egistrar's Signatu	arke	,								

DHMH 17 Rev 1/2001 11595

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Items 23a per dr.,g922 12/22/2011dhb

Red, No.

Red, No. 41066 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year Arthur Albert Gray Jr 2011 0Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Good Samaritan Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours M 2 □ F 06/09/1952 Maryland 214-58-5860 Director 59 Yrs. Usual Residence of Decedent 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits notified 1x Yes 2 No N/A MD Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 1601 Chilton Ave. 21218 U.S.A. items "natural", or iten ledical Examiner r Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Artwor, Gray Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Divorced Specify: Black uth and Mental Hygiene. 27 is marked other than "natur r traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry **BethLehem** (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Steel Mill Worker 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Albert Gray Sr. Harriett Jane Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Leah M. Gray(daughter) 2300 W. Lanvale St., Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 12/14/11 Baltimore, MD Signature of Funeral Service Licens Joseph H. Brown Jr. Funeral Home PA Þ 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on failuline. Approximate Interval Between Immediate Cause (Final Onset and Death wilus Ph. sician/ disease or condition Medical resulting in death) Examiner Myocardial Infarction Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year should be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, Probably 4 Unknown 1 Yes 2 No 3 5 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed this certificate 1 Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 🗌 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 4 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident the within 24 hours after deal To the Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nume Practioner: T. The best of my knowledge, death continued at the time date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number

Registrar

State

Date filed (Month, Day,

se of death (Item 23a) (Type, Print)

32. Fegistrar's Signature

168760 Cd Baltimore, Maryland 21215-0036

			Please	e Type or Pri				•		Legible.							
	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 1 1 1																
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ш	Physicia Medi		Frances K	atie	Louise	Har	mon	December	er Day	O ZOII	01:13 A M						
, hope,	Examir		4a. Facility Name (if not institution, give Sinai Hospital	of Balti	more	Baltin	r Location of Death		4c.	County of Death	1						
	Funeral Director		Social Security Number 6.	Sex 7. Age 1 □ M 2 🔏 F	76 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 05 1	ay, Year)	Cou							
	Aaryland 8a-f show tified at	Director	10a. State 10b. County NA		10c. City, Town or Balt	location imore					10d. Inside City Limits 1X Yes 2 □ No						
	with the h s 23a or 2 ust be no	Funeral Di	10e. Street and Number 3102 Clifton A	ve		10f. Zip Code	1216		10g. Citi								
9800	riit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 [X] Widowed 4 ☐ Divorced	12. Was Decedent Et Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates.	ver in U.S. 13	B. Was Decedent of H If Yes, specify Cub 1 Yes X No		ecify Yes or No- Rican, etc.)		Black, White,	, etc.						
21215-0036	within 72 hor giene. ner than "nat ner the Medica", the Medica	Completed	15. Decedent's (Specify only highest g		H) life.	during most of work	ing	16b. Kii	3. Time of Death Country of Death 9. Birthplace (State or Foreign Country) SC 10d. Inside City Limits 1X Yes 2 No izen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black Ind of Business/Industry Private Surname) Town, State, Zip Code) Town, State, Zip Code) Approximate Interval Between Onset and Death Syeavs Approximate Interval Between Onset and Death Syeavs 23d. Date of delivery Month Day Year See contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Other (Specify)								
Maryland 2	d be filed w Mental Hygi irked othe tic event,	l on l	17. Father's Name (First, Middle, Last) James Butler		I		18. Mother's Nam			Gurname)	-						
, Mary	nd 2 should be salth and Ments n 27 is marked er traumatic e		19a. Informant's Name/Relationship (er 741	iling Address (Street O Brixwo	and Number or Run	al Route Numbe	er, City or 302	Town, State, Zip Winds	Code) 21244 Sor, Mill						
Baltimore,	permit. Page 1 and Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		cemetery, ci	position (Name of ematory or other place Site	ce)	Date 9/2011	1	•							
Ball	permit. F Departm Importa any inju		21. Signature of Fundal Service Liver	and of		22. Name and Addre	H West	n - 1 +		- M -	21215						
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	ate be executed physician and the burial-transii	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):												
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	nysician/Me		nysician/Me	hysician/Me	nysician/Me	nysician/Me	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	Petal death 3	Cother (specify)	су		2		
ds, P.O.	luires that t on signed b uld be deta	ed by PI	Part II. Other significant conditions of the significant condition	contributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.	23e. Did t									
Records,	Physician: The law rec this certificate has bee al director, page 2 sho	Somplet						24a. Was auto perfe 1 \(\sum \text{Yes}	psy ormed?	prior to co death?	ompletion of cause of						
ţa	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		12	ace of Death (Check										
of <	y Physer this erral di	e: 10	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatier 28a. Date of injury	nt 2 ER/Outpat	of 28c, Injur	4 U Nursing Ho	ome 5 Resi 28d. Describe I			(y)						
ono	Attending Ph ar death. ector: After thi by the funeral	Certificate:	1 Natural 5 Pending 2 Accident Investigation		Year) injury	work	(? Yes 2 □ No		,,,,,,								
Division of Vital	ne Hospital or Attendir n 24 hours after death. Ie Funeral Director: Af oletely filled in by the fu	al Certi	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined														
	thin 24 hor thin 24 hor the Fune	Medical	(Check 2 \(\subseteq \text{Medical Exam}	on, death occurred a the time, date and pla	t the time, date a	and place, the cause(s	and due to the cass) and manner as	ause(s) and manner stated. stated.									
	5. ≥ 5 8		1 Justin D.	Mann, M.			S - COO										
	Stat		30. Name and address of person who Tustin D. Ma 31. Date filed (Month, Day, Year)	NN M.D.	Sinai t	tospital of	Baltimo	re									

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		-	ForState	State of Marylar				ientai Hygie	ene	11 11000	
			Registrar		Cei	tificate of D	<i>Jeath</i>		g. No.	11 41000	
	Physicia Medic	n/	1. Decedent's Name (First, Middle, La.	Houpe				2. Date of Death Month	19- 5	3. Time of Death 9:10 AM	
Contract of the Contract of th	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NA WA								
	Funeral		5. Social Security Number 6. 6	ex 7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear)	Birthplace (State or Foreign Country)	
	Director		245-46-9675 1 Usual Residence of Decedent	□ M 2 X F	30 Yrs.	Widitiis Bayo	Tiouro Iviini		931	N.C.	
	land Fshow	tor	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits	
	Mary 28a-1 otifie	irec	MD N	4 B	altim					1 X Yes 2 □ No	
	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at	Funeral Director	5200 Bowley	clana And	.311-	10f. Zip Code	21206	10	g. Citizen of W US-		
	eath v	Fune	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	14. Race	- American Indian,	
36	fter d	þ	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		f Yes, specify Cuba 1 ☐ Yes 2 🗷 No		rican, etc.)	Black Specify:	K, White, etc. Black	
21215-0036	ours a atural	Completed	3 Widowed 4 Divorced 15. Decedent's 8	Year or Dates.		dent's Usual Occupa				siness/Industry	
-51	72 ho an "na Medic	mple	(Specify only highest gr	ade completed)	(Give	kind of work done o O NOT use retired)	during most of work	ing	bb. Kina or bu	siness/industry	
212	within giene. er tha , the l		Elementary/Secondary (0-12)	College (1-4 or 5+)	Seo	imstress		4	rape	ry Contractors	
	1 and 2 should be filed within 72 hour of Health and Mental Hyglene. Item 27 is marked other than "natun other traumatic event, the Medical	To Be	17. Father's Name (First, Middle, Last)	1			,	e (First, Middle, Ma	A IL		
r <u>y</u> la	uld be d Men marke natic		Robert (othange	1.0. 1.0	ng Address (Street a	Lonne			er son	
Maryland	2 sho Ith an 27 is r		19a. Informant's Name/Relationship (1	- David Liles	343	S Chacla	and Number of Hurs	- R11	in or lower, si	UN 2/2/3	
	1 and of Heal item 2		20a. Method of Disposition			sition (Name of natory or other place				City or Town, State	
imo	Page nent c ant; If ury or		1 Burial 2 Cremation 3 C	nemoval nom state	arden	of Faith	1 12/2	9/2011 /	Baltimo	te, MD	
Baltimore,	permit. Page 1 a Department of I Important: If its any injury or of		21. Signature of Funeral Service Licen			2. Name and Addres	ss of Facility Ma	irch F/H B	East 11	OIE, North Ave.	
	<u> </u>		23a. Part 1. Enter the disease, or com	plications that caused the deat	th. Do not ent	er the mode of dvin		21202	1.	Approximate	
le.	olessisies (shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	S O	Ca	C 0 -	,	,	Interval Between nset and Death	
	hy ician/ Medical		disease or condition resulting in death)	a. Due to (or as conseq	ju≕ho'∈ of):	Came	سسا ريك			4 menting	
	Examiner	١	Sequentially list conditions,	b. ————————————————————————————————————							
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Box 6876(death certificate be ne attending physici ed for use as the bu	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnate 1 Live Birth 2 Fet 4 Pregnant at time of	al death 3	Ectopic pregnanc	су		23d. Dat Mor	e of delivery hth Day Year	
. B	re dea / the a	nysic	1 Yes 2 No 9 Unknown	9 Unknown	death 31						
P.0.	Attending Physician: The law requires that the death certificate t actor adth. screen and the this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medic	Part II. Other significant conditions	ontributing to death but not re-	sulting in the	underlying cause giv	ven in Part I.	23e. Did toba	icco use contr	ibute to the cause of death?	
ds,	quires en sig ould b	ted						1 🗌 Yes	s 2 □ No	3 Probably 4 Unknown	
cor	law re nas be e 2 sh	nple						24a. Was an autopsy perform	· I p	Vere autopsy findings available orior to completion of cause of leath?	
Re	r. The icate I	Cor	- W					1 🗌 Yes 2		Yes 2 No	
/ital	sician certif lirecto	m i	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outpotio	Oth	er:		os 6 🗆 Othe	or (Specify)	
of V	g Phy er this neral d	te: To	27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time o		y at	28d. Describe how	ence 6 Other (Specify) ow injury occurred		
on	endin eath. or: Aft the fur	fica	1 Natural 5 ☐ Pending 2 ☐ Accident Investigatic 3 ☐ Suicide 6 ☐ Could not I	n	injury	M 1 🗆	Yes 2 No				
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 seminates of the funeral director, page 2 seminates of the funeral director.	Certificate:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		eet, factory, office		28f. Location (Stre City or Town,		er or Rural Route Number,	
Q	sspital hours neral y fillec	Medical	29a. Certifier 1 Certifying Phy	sician: To the best of my know	vledge, death	occurred at the time	e, date and place, a	and due to the caus	e(s) and mann	er as stated.	
	the Ho	Mec	only one) 3 🗆 Certifying Nu	iner: On the basis of examination se Practitioner: To the best of	my knowledge	, death occurred at t	the time, date and pl	ace, and due to the	cause(s) and m		
	5 4 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6		29b. Signature and title of certifier	aell .		29c. License	e number	29	id. Date signed	(Month, Day, Year)	
	1.		20. Name and address of payour who	completed cause of death (Iter	m 23al (Time	Profit	74				
	41		30. Name and address of person who	1FMD, 5601	Lock	Ravey	Blue,	Sattir	note il	W 2/239	
	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature Sav	w					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death Month Grethe Hägglund December 2011 10:50 P^M 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not Institution, give street and number) 3511 Fitzhugh Lane Silver Spring Montgomery 8. Date of Birth (Month, Day, NOV 2, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Days 047-40-4565 92 Denmark 1 □ M 2 🛛 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 3511 Fitzhugh Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arvid Nilsson Signe Christensen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3511 Fitzhugh Lane Silver Spring, mD 20906 Erik H. M. Hägglund/husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 12/22/11 Woodbine, MD 4 Donation 5 Other (Specify) e of Funeral Service Lice Ging Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death

Ph_ysi ian Medical **Examiner**

Department of Health a Important: If item 27 is any injury or other tranonce.

Physician/

Medical

Director

Funeral

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Completed

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Examiner

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notified 28a-f

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical

Completed by

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Certificate:

Medical

29a. Certifie (Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Xiaochun Sharon Yang,

DEC 2 2 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the Hospital or Attending Physician: The law requires that the death certificate be executed

Records, P.O. Box 68760

Division of Vital

Examine

disease or condition	Advanced Dementia			
resulting in death)	Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or Injury	b. Due to (or as a consequence of):			
that initiated events resulting in death) Last	c			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No g ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year		
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ※ No 3 ☐ Probably 4 ☐ Unknown		
		24a. Was an autopsy performed? 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{X} \text{No} \) 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{X} \text{No} \) 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{N} \text{No} \) 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{N} \text{No} \) 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{N} \text{No} \) 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{N} \text{No} \) 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{N} \text{No} \) 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{N} \text{No} \) 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{N} \text{No} \) 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{N} \text{No} \) 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{N} \text{No} \) 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{N} \text{No} \) 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{N} \text{No} \) 1 \(\begin{array}{ll} \text{Yes} & 2 \(\mathbb{N} \text{No} \) 1 \(\begin{array}{ll} \text{Yes} & 2 \mathbb{N} \text{No} \)		
25. Was case referred to medical	26. Place of Death (Chec	ck only one)		
examiner? 1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 X Residence 6 🗆 Other (Specify)		
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigatio		28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	1 28a Place of Injury - At home form street tactory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

M.D. 3305 N. Leisure World Blvd. Silver Spring, MD 20906

29d. Date signed (Month, Day, Year) December 21, 2011

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D61696

DHMH 17 Rev 06-2011

State

Registrar

11-09482 Danielle Higgins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

anielle i	nggino		1- For State Registrar	State of Maryland		rtificate of Dea			Reg. No.	114101
	hysici	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Ye							3. Time of Death 1212 hrs
ledical	Exami	ner	Danielle Anto 4a. Facilify Name (if not institut			4b City	, Town, or Location		er 17, 2011 4c. County of De	
			St. Agnes Hospital	ion, give on out and name of			imore		n/	
	uneral rector		5. Social Security Number 217–84–2407	9. Fo 27/1973	Birthplace (State or reign Country) MD					
	any		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City	, Town or Location				10d. Inside City Limits
P		۲	MD	n/a		В	altimore			1 XYes 2 No
Maryla	28a-f show d at once.	Director	10e. Street and Number			10f. 2	ip Code		10g. Citizen of What C	country?
th the	23a or 28a-f sho notified at once.	Ö	3028 Chelsea	Terrace	Consis II	C. Ld2 Wes Dags	21216	gin? (Specify Yes or N	USA	nerican Indian, Black,
er death wi	, or items r must be	Funeral	-X -	Married Armed Forces?		If Yes, spe		, Puerto Rican, etc.)	White, etc.	3.
ours aft	tural"	d by	4 Divided of Business (Specify only bishest grade completed) 16a Decedent's Lignal Occupation (Give kind of work done 16b Kind of Business (Specify only bishest grade completed)							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland	dental Hygiene. narked other than "natural event, the Medical Examin	Completed	Elementary/Secondary (0-12	2) College (1-4 or	5+)		r Service		Telecommu	nication
21215-0036 uld be filed within 7	and Mental Hygiene. 7 is marked other thatie event, the Med		17. Father's Name (First, Midd Robert Higgir					r's Name (First, Middle Olyn Darne		
212 uld be	Mental I marked c event,	To Be	19a, Informant's Name/Relation				ss (Street and Nur	mber or Rural Route N	umber, City or Town, S	tate, Zip Code)
MD d 2 sho	lealth and N tem 27 is n traumatic		Miesha Daniel	s- Daughter				Baltimore		Town State
ore,	Department of Health and Important: If item 27 in injury or other traumat		20a. Method of Disposition 1 Burial 2 Cremati	ion 3 Removal from St	ate	Place of Disposition (Note of	ce)	Date 12 29 201	20c. Location - City 1 Hanover,	
Baltimore, permit. Pages 1 ar	ortant:	1	Donation 5 Other 1. Sign three of Funera String	Specify:	Aı	rdent Crema			Directors	
Be Be	Departi Importi injury	2.2	VALUE J.V	1000		4517	Park Heig	nts Avenue	Baltimore	, MD ZIZIS
	sician	3	23a. At I. Enter the disease, ailure. List only one caus		I the death	n. Do not enter the mod	e of dying, such as o	cardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and Death
	ıminer		Immediate Cause (Final disea or condition resulting in death)		equence o	of):				1
		_	Sequentially list conditions,	b.	editence /	×1.				
		Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Clisease or injury that is flicted							
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se execu	ysician and burial - tra	Medical	X UNPENDED	AMENDED 23a	,,pt	.II,27,per	me,g923 1	-13-12 sm		
Division of Vital Records, P.O. Box 68760,	e attending physi for use as the bu		IF FEMALE: 23b. Was decedent pregnant in past 12 months?	23c. If yes, outcoment the 1 Live birth		2 Fetal dea		ic pregnancy	23d. Date of deli Month	very Day Year
e death	the atte	hysi	1 Yes 2 No 9 ✔ L	5 Olikiowii					1	1. (I
, P.O.	signed by I be detach		Part II. Other significant cond Drug Abuse	Jitions contributing to deat	h but not i	resulting in the underly	ng cause given in P	GIT 1:	es 2 No 3	e to the cause of death? Probably 4 Unknown
of Vital Records, g Physician: The law requir	has been 2 should	Completed by						per	opsy prior form <u>ed</u> ? deat	
- 8 ±	his certificate has director, page 2 sl		25. Was case referred to medi	cal			26.Place of Death		3 2 ✓ No 1	Yes 2 No
Vita	this ce	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	ent 2 🗸	ER/Outpatient 3	DOA Other	Nursing Home 5		ther:
on of	th. r: After e funera		27. Manner of Death 1 X Natural 5 Pe	28a. Date of Inju (Month, Day,) ending	ury Year)	28b. Time of Injury	28c. Injury at Wor	_	e how injury occurred	
Division tal or Attendi	ours after death eral Director: filled in by the	ertification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Num or Town, State)							r Rural Route Number, City
the Hosp	within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying	Physician: To the best of manner: On the basis of examiner: and manner stated.	ny knowled amination	dge, death occurred at and/or investigation, in	the time, date and p my opinion, death o	lace, and due to the ca	use(s) and manner as te and place, and due t	stated. o the cause(s)
29b. Signature and title of certifier								29d. Date signed		
				y Mi	11		O.C.M.E.		December 18	, zuii
			30. Name and address of personal Jack Titus MD. D	son who completed cause of c eputy Chief Medical E			nore Street, Bal	itimore, MD 2122	3	
	S	tate	31. Date filed (Month, Day, Yea		ar's Signa	ture Land				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:20A 20,2011 December Richard Earl Hamilton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 217-22-7154 **Director** 1 X M 2 🗆 F 81 December 13,19|30 Maryland Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or other traumatic event, the Medical Examiner must be notified Balto. 1 Yes 2 X No Md. Nottingham 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a Funeral 7 Whips Lane 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2x Married 1 Yes 2X No Specify White Specify 3 Widowed 4 Divorced Completed Year or Dates. 1955–1959 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore Co. Schools Instructional Asst. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matilda Scheuerman Wilbur L. Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham, Md. 21236 7 Whips Lane Mary A. Hamilton Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12-23-2011 Balto.Md. Most Holy Redeemer 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Schimunek FuneralHome, Inc. 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 21236 23a. Pact 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, i.i.n disease or condition resulting in death) COLON CANCER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of dgath? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Division Certifical 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier MORGAN CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 TRACIE L.

DHMH 17 Rev 06-2011

State Registrar

a.m.

DECEMBER

RICHARD HAMILTON

32. Registrar Signar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dal 9, 2011 December Thomas Phillip Haun 10:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Potomac Valley Nursing & Wellness Center Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Country) 414-16-3057 91 **Director** 1 X M 2 🗆 F Yrs Tennessee December 4, 1920 Usual Residence of Decedent 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Ocean City 1 K Yes 2 No Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21842 778 94th Street, #111 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō Ś 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify. "natural", Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Mechanical Insulation Elementary/Secondary (0-12) College (1-4 or 5+) the Union Insulator/Asbestos Worker 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o မ should be John R. Haun Savanah Latham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sharent of Health a tant: If item 27 is Thomas Haun/Son 1005 Deep Creek Avenue, Arnold, Maryland 21012 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. December 22 1 M Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 3 0 West Montgomery Avenue
Rockville, Maryland 20850 21. Signature of Funeral Service Licenses 20 M01498 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Week Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Dause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🔀 No ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 Pending within 24 hours after death

To the Funeral Director, A
completely filled in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anurita Mendhiratta,

31. Date filed (Month, Day

MD

32. Registrar's Sign

D38262

9043 Shady Grove Road, Gaithersburg, Maryland 20877

December 19, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 16, 2011 5:00 P M Helen H. Hafner Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Emeritus at Potomac Potomac Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 074-14-3362 93 Director 1 M 2 X F February 5, 1918 Pennsylvania Usual Residence of Decedent 28a-f show an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery Gaithersburg 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 216 Massbury Street 20878 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Hughes Lucille Dalton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 William A. Hafner/Son 216 Massbury Street, Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ott Montgomery Crematorium, Inc. December 21 1 🗌 Burial 2 🕱 Cremation 3 🗋 Removal from State 4 Donation 5 Other (Specify) 2011 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Inc. 300 West Montgomery Avenue M01498 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final Onset and Death Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events Anemia the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Psychosis Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d Date of delivery ō in the past 12 months? Month 1 ☐ Yes 2 🔀 No g ☐ Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has h autopsy performed 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) ျှ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of .28c. Injury at work? 28d. Describe how injury occurred After X Natural 5 Pending Accident 1 Yes 2 No Investigation within 24 hours after deati To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D0067092 December 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Weihan Wang, MD

32. Registrar Signatu

15245 Shady Grove Road, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G923, 1/10/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:20 A larion Medical cility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holling Haltimore are If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min Director 1 🗆 M 2 💢 F or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Completed by Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working . DONOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Stee 14h MOYKER Be ther's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surnar ၉ towell ara nformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number Niece SE 3300 Ave Alabama Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location Date Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Raltimore Funeral Service License 23a. Part 1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician SEVERE PULMONARY HYPERTENSION disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 27 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC FLONEY D158A-58 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10059107 M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN MD 21136 210 BUSINESS CENTER DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **DEC 22** Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per me 9922,12/16/2011dhb
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ DECEMBER 1, 2011 Ireland 2:15A Robert H. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **TOWSON** 4c. County of Death
BALTIMORE **Examiner** CENTER SAINT JOSEPH MEDICAL 6. Sex Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 142-18-3337 **Director** 93 1 X M 2 🗆 F Sept. 2 1918 New Jersey Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10b. County Examiner must be notified at Director Baltimore Timonium 1 Yes 2 XNo Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral or items 23a U.S.A. 2525 Pot Spring Road 21093 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 X Married 🗌 Yes 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important. If item 27 is marked other than "naturany injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Aberdeen Proving Ground Mechanical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cora Phillips Herbert Ireland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Pot Spring Road K107 Timonium, Md. 21093 Doris H. Ireland / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
HilltopServiceCorp. 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 12/5/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRuck Towson Funeral Home, 21, Signature of Funeral Service Licenses 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERE SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** PNEUMONIA CERTIFICATIO AF RO EDI ALE JINER Sequentially list conditions, Examine Directo (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown Unknown After this certificate has been signed by funeral director, page 2 should be detac art II. f Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. $f ACUTE\ KIDNEY\ INJURY$ 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an COMPLETE HEART BLOCK autopsy performed? the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 X Yes 2 X No Other: ၉ ER/Outpatient 3 DOA 1 🕅 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) within 24 hours arter www. To the Funeral Director. After the 27. Manner of Death 1 X Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number 12-2-11 D30263 D. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, M.D. 7601 OSLER DRT 7601 OSLER DRIVE TOWSON, MD 21204 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Alvin Davis Jenkins 2011 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death City Baltimore of Boltimon N/A 9. Birthplace (State or Foreign Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Social Security Number **Funeral** Min **Director** 418-36-0918 81 1 □ M 2**X** F June 5,1930 Alabama Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A 1X Yes 2 ☐ No Baltimore Maryland 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 21215 USA 3801 Calloway Ave Apt.1A 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: Black 3 Divorced 4 Divorced Completed er than "natur, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MTA Bus Driver 12th grade permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mance Jenkins Alma Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 Calloway Ave Apt.1A Baltimore,MD 21215 Willa D. Jenkins/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Alexander City,Alabama Rocky Mount Cemetery 12-29-11 22. Name and Address of Facility Chatman—Harris Funeral 5240 Reisterstown Rd Baltimore, Maryland Signature of Funeral 5 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph. sician/ ordiac Medical resulting in death) **Examiner** Sequentially list conditions, if only leading to immediate cause. Enter Underlying Datie Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 No 1 Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 No Accident Investigation 1 Yes 24 hours after death Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one nd title of gertifier December 21, 2011 N44841 w and address of person who completed cause of death (Item 23a) (Type, Print)
CC SUSSMAN MD 4940 Eastern Avenue Bultimore Maryland 6V Marc Sussman MD 31. Date filed (Month, Day, Year) ₽32. Registrar's Signature State Registrar

AND JOKE

KNOWN:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 11077 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Year Jones Laura 9:00 A December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 733 Roundview Road 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 77 219-32-8517 Director 1 🗆 M 2 💢 F 01 34 11 GA Usual Residence of Deced 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified Baltimore 1 No MD NA 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21225 U.S.A. 733 Roundview Road items death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give be filed within , sential Hygiene.

arked other than "natural", o Baltimore, Maryland 21215-0036 Black 1 Yes 2 Xio Specify. 3 Widowed 4 XDivorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Correctional Officer State of Maryland 2yrs+ 2 should be filed with th and Mental Hygien 7 is marked other ti 12th grade traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mabel Finley Walter Jones Sr. 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 other tra 7111 Kempton Road, Lanham, Md 20706 <u>Cheryl Jones-McCottry</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other placel 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 12/29/2011 Arbutus, Md 22. Name and Address of Facility ABCH Wabash Ave, f Funeral Service License Baltimore, Md Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Cancer disease or condition resulting in death) Utering Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). and I-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Yes the Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performed? Yes 2 No 2 No 1 Tes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 🖪 No Hospital Other: 1 Tes ျ Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work' safter death.

I Director: Af 2 Accident М Yes 2 🗌 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, MS/Wapahum's 00057465 12/14/11 10

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day

DEC

2835 Smm

AV 57.03

Baltomer MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NS-Rajapalon M.D

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year RRIE-**Physician** 0145 AM JIGGET 20 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Homewood Baltimore are Date of Birth (Month, Day, 2/30 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF Months Days Hours 237-54-591 Director 0 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ir than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MMORE 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 1803 USA 21213 line by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 27 is marked other than traumatic event, it a Ma College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. 12Fh etician oserph 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h Williams Williams lary ပ္ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's e/Relationship (Type, Print) is 1 and 2 soft Health an Itam 27 is 20b. Place of Disposition (Name of Cometery, crematory or other place) Baltimore, MD 21207 Nephew Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ital
any Injury or oth 12/27/2011 Harethorie Memorial fork Hrbutus March FIH East 1101 E. North 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, MD 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementa **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is presented to the cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner nding physician and use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for u 3 □Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. I been signed by the c should be deteched 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 2000 this certificete 2 No 1 ☐ Yes Physician: : After this certifical funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 EN6 1 Inpatient 2 ☐ ER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred Injury at Work? or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Records. Division of Vital To the Hospitel or Attendii within 24 hours after death. To the Funarel Director: A filled in by the

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

31. Date filed (Month, Day, Year,

of newson who come

2 2

leted cause of death (Item 23a)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 20c,25 per in me Deportment of Jean Mental Hygiene Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jett Jean, 201 November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital andalstown Baltimore Novenwest If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10h County 10a State 10c. City, Town or Location ir than "natural", or items 23a or 28a-f sho Baltimore 1 ☐ Yes 2 XNo MO Director reisterstaur 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 Place Bannot Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: Back 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Security marked other than College (1-4or 5+) Elementary/Secondary (0-12) Administrative Clerk Administration 12th grade 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Mary Irvina Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informants Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau
once. Kichard Anderson/Daughter Place Reisterstrum MD 21136 Bonnot 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/2011 Woodlawn Carreter Woodlawn III 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vallynn C. Greane Funeral Services 8728 Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestiva heart 10 days **Physician** /Medical Due to (or as a consequence of) Examiner hours urosepsis Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). attending physician a for use as the burial-CERTIFICATION Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Dav Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Injury 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D70334 November 4, 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print)
- jun Zhon 2835 Smith Ave, Suite 203, Baltimore, MD 21209 -junZhon 31. Date filed (Month, Day, Year)
DEC 1 6 2011 32. Registrar's Pignature State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20° December Lawrence Jenkins 2011 2:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 219-18-8125 Days Hours Director 1 X M 2 □ F 86 11-11-1925 Maryland ms 23a or 28a-f show must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Parkville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8810 Walther Blvd Apt. 1123 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?
1

Yes 2 □ No 5 1 Never Married 2 Married Black, White, etc. Yes, Give Baltimore, Maryland 21215-0036 "natural", 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced WII Year or Dates. traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. d other than " Elementary/Secondary (0-12) College (1-4 or 5+) B.G. & E. Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i and 2 should be file I Health and Mental H Item 27 is marked of ပ Annie Sinnott William Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia Arcilesi - Neice 2710 Beechwood Lane Fallston, Maryland 21047 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 12-23-2011 Baltimore, Maryland 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as the l IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 I Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death ne Hospital or Attending Pl n 24 hours after death. Re Funeral Director; After the pletely filled in by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1X Natural 1 Tyes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the I priy one) critifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of 29d. Date signed (Month, Day, Year) 781 1500C 12-20-11 ûte 4105, Balthure, MD 21204 6701 N. Charles State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0.00 EOdo 201 25 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE LOCHEARN AUGSBURG LUTHERAN HOME 9. Birthplace (State or Foreign Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🕱 M 2 🗆 F Hours (Month, Day, Year) 11/26/1929 MARYLAND Director 212-26-5408 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 XNo CATONSVILLE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21228 27 ANDERSON RIDGE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc ğ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 X Divorced WHITE Year or Dates. KOREAN Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) MACHINIST RAILROAD 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ ANNA C. HORN ALFRED T. JACOBSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CATONSVILLE, MD 21228 ERIC T. JACOBSON/SON ANDERSON RIDGE RD. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State DULANEY VALLEY MEM. 12/27/2011 COCKEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) GARDENS Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MOO2.17 TOWSON. MD 8521 LOCH RAVEN BLVD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to or as a consequence of if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 No signed by the a 9 Unknown Part linother significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 1 Yes No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Other: a No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral (27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year) 02855 un ALLEGI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACTOMID 2120

State Registrar Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar	State of M	arylan		artment <i>tificate</i>			and Me	ntal Hy	giene	2011	41082
18	Dhusisi		1. Decedent's Name (First, Middle,								Date of Dea		Year	3. Time of Death
V AL	Physici /Medic	cal	Gerard Anthony								Decemb			5:45 PM
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	Funeral		5. Social Security Number	6. Sex 7. Ag		iast birthday)	Il Under		If Under 2	24 Hrs. 8	Date of Birt (Month, Da ebruar			lace (State or Foreign
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Maryland 21215-0036 Id 2 should be filed within 72 hours af	edment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Madical Examinational Lanchilled at 8.	ဥ	19a. Informant's Name/Relationsh			19b. Mailir	g Address						or Town, State, Zip	Code)
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more	or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 Removal from State		lace of Dispo emetery, crer				Dat			ocation - City or To	
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일 및	by the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at 9 □ Unknown	time of de	eath 5	Other (spe	ecify)						54, 754,
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	h. After th funeral		27. Manner of Death Satural 5 Pending		ry y Year)	28b. Time of Injury		3c. Injury	?		d. Describe l	how inju	ry occurred	
UNISION or Attending	death ctor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	ot be 28e. Place of Inj	ury - At ho	ome, farm, str	M eet, factory,		es 2⊡N				nd Number or Rur	al Route Number,
5 8	siDire aiDire ed in by	Cert	4 Homicide	building, et	c. (Specify	v) 					City or Tov	wn, State	9)	
Hospitei	within 24 hours after to the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one)	Physician: To the best xaminer: On the basis o and manner st	f examinal	wledge, death tion and/or in	occurred a vestigation,	it the time in my opi	e, date and nion, deat	d place, an th occurred	d due to the l at the time,	cause(s date and) and manner as s d place, and due t	itated. o the cause(s)
To the	To the	Me	29b. Signature and title of certifier				29c.	License	number			29d. Da	te signed (Month,	Day, Year)
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13			30. Name and address of person w		leath (Item	1974 1974	Print)	1051	tia	Par	-10 (rel	Corne	tura MD
6. 1	Sta	te	31. Date filed (Month, Day, Year)	Several S	's Sign	lure V) レ)	LCLV	1100	100		., 0.	, O ET TYL	20874
	Registr		DEC 2 2 2011	Denous &	. 14	aus								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Lena C. Kemp 20:46 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Balto. Towson Lorien Mays Chapel If Under 1 Year If Under 24 Hrs. 9, Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 F Mary land 214-14-4319 102 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Md. Balto. Nottingham 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4111 Perry View Road USA 21236 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Schmidt Annabelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Vittek Perry View Road Nottingham, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Gardens of Faith 12-22-2011 Balto.Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facilityschimunek FuneralHome, Signature of Funeral Service Licensee 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, o complications that shock, or heart failure. List only one cause on e caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final √nysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2/ 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 X No 은 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending death. Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 3 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) R080210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARLES ST, SUITE 410 0

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 41084 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kenneth R. LaRicci Month Day 2238 Physician/ 20 2011 Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Belair Harford Upper Cheaspeake Hospital If Under 1 Year If Under 24 Hrs.
Pays Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 50 (Month, Day Year) 961 212-82-3586 MD **Director** 1 🛛 M 2 🗆 F Usual Residence of Dece 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shortmast be notified at 10a. State Director PA Red Lion York 1 Yes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 17356 404 Woodsdale Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deal Obepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces? 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Self-employed College (1-4 or 5+) Construction 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Naomi Johnson Anthony LaRicci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8824 Avondale Road Baltimore MD 21234 Joseph LaRicci /brother 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Holly Hill Cemetery 12/23/1 1 X Burial 2 Cremation 3 Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace 21. Signature of Funeral Service Licenses Ave. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Return Interval Between Onset and Death Immediate Cause (Final Physician/ oca disease or condition Medical resulting in death) equence of) Examiner Sequentially list conditions if any leading to immediate cause. Enter Underlying Examir Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 1 Yes 2 L signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a, Was an cate has t autopsy performed? Yes 2 12 No 4800397451 to the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral According 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 🗆 No 2 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 'Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year, 29b. Signature and 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

-ermin Barrue

31. Date filed (Month, Day, Year)

100 2238

500 Upper Chesapeake Dr Bel Air, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Day Patrick Brian Lannon 2011 1:55 A M Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Westminster Carroll County General Hospital 8. Date of Birth (Month, Day, Y July 10 If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Days Min 1 XM 2 - F Director 1959 212-80-8580 Usual Residence of Deceden show Silvous with Mydene. and Mental Hygiene. rise marked other than "natural", or items 23a or 28a-f show it is marked other than "natural", or items 23a or 28a-f show it is marked other than Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛣 No Hampstead MD Carrol1 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21074 USA 849 Century St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: white If Yes. Give Specify: 3 Widowed 4 XDivorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Production Scheduling Spice Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important. If item 27 is marked o any injury or other traumatic eve Miriam Virginia Westphal John Joseph Lannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 849 Century St., Hampstead, MD 21074 Patrick John Lannon/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 12/22/11 Denation 5 Other (Specify) Dulaney Valley Memorial Gardens Bryan W. (22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley. 10 W. Padonia Rd., Timonium, MD 21093 Crary 23a. Part 1. F ter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock r heart f lure. List only one cause on each lije. Approximate Interval Between Onset and Death Immediate ause (Fi al Pnysician tolmo several years disease or condition resulting in (1997) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No has page death? this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? 2 **X** No Hospital Other: |은 1 🗌 Yes 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death. neral Director: After that filled in by the funera 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pendina M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours a Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor **To the Fune** completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4231 Northwoods Trail, Hampstead, MD 21074 Domingo Rocha, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	for Amend Items 2 State Registrar	881-c, 25 Mar Pe	Yland /	Gepa Cert	12916920 ificate of D	99 thang 3 Death	artiti	giene Reg. No.	2011	11006
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea		ZUII	3. Time of Death 0
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	Funeral		5. Social Security Number 6. Se	x 7. Age (i	In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Date 04/05/	h Vear	9. Birthp	lace (State or Foreign
	Director		Washi	ngton, DC								
ī	T OM		Usual Residence of Decedent 10a. State 10b. County			0d. Inside City Limits						
	yland f sh ed at	cto			IOc. City, Tow							1 V Yes 2 □ No
	Mar 28a notifi	Director	Maryland N/A		Balti	more						72
	th the	10e. Street and Number 10f. Zip Code 110g. Citizen of What Indicated Street and Number 1113 N. Rock Glen Road Apt. C 21229 United Street and Number 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Notice of the Street of Version Plant of Street of Version Plant of Version Pla										
	th with ms 2; must											
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates.	er in U.S.	If '	as Decedent of His Yes, specify Cubar Yes 2 X No	n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		Race - Americ Black, White, e ecify: Whi	etc.
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Baltimore,	it. Page 1 rtment of rtant: If it rjury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	cemete	ery, crema Olive	t Cenete	ry 11/1	9/2011	Washi	ngton,	DC
Bal	permi Depar Impo any ir		21. Signature of Funeral Service License	ee		Da 53	Name and Addres YIC J. W 11 Edmon	eber Fundson Ave	eral Hor nue Balt	nes P.	A. Mary	Land 21229
П			23a. Rart 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the	ne death. Do	not enter	t - ode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
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Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affard eath. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal dea		Ectopic pregnancy Other (specify)	у		230	d, Date of delive Month	ery Day Year
Ö.	hat thed by detac		Part/II. Other significant conditions co	ntributing to death but	pot resulting	in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use	contribute to th	ne cause of death?
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U.	ath. r: Aft	icat	1 √atural 5 ☐ Pending 2 Accident Investigation	(Month, Day,	rear)	injury	work'	/ Yes 2□No				
Division of Vital Records, P.O.	tal or Attending Physician: The law rest after death. The state death. I Director: After this certificate has be ed in by the funeral director, page 2 shed in by the funeral director.	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (farm, free	t, factory, office		28f. Location (S City or Tov		umber or Rural	Route Number,
	ne Hospit in 24 hour ne Funera pleted fille	Medical	(Check 2 Medical Examin	ician: To the best of m ner: On the basis of exa e Practioner: To the be	mination and	or investig	gation, in my opinio	n, death occurred a	at the time, date a	and place, an	id due to the ca	use(s) and manner stated.
	To t To t		29b. Signature and title of certifier) et			29c, License	number 6 773 6		29d. Pate s	igned (Month,	Day, Year) 5th, 2011
· · · · · ·	0		30. Name and address of person who c	ompleted cause of dea	- 0	V	plain &	r. Ba	ltimore,	MD	2120	4
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	Registr	ar	DEC 1 6 20	11 June	J.	100	ale					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Description of the property				For State	State of Maryland /	Department of Health a Certificate of Death	and Mental H	20	11 1.1087
Properties Pro				Registrar 1. Decedent's Name (First, Middle, Las	st)	Certificate of Death			3. Time of Death
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State Part								Birth Dav. Year)	9. Birthplace (State or Foreign Country).
State Control Contro	Ġ.				□M2 V 88		10/2	7/1922	
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20a. Method of Disposition 1 City or Town. State Date	pue	e filed ntal Hy ed oth event	o Be	17. Father's Name (First, Middle, Last)	/	2/		e, Maiden Surname)	10
20a. Method of Disposition 1 City or Town. State Date	aryle	ould b nd Mei mark imatic		19a. Informant's Name/Relationship (7	Q N / C / S	· · · · · · · · · · · · · · · · · · ·		DANIE! ber. City or Town. Sta	te. Zip Code)
State Continue C		nd 2 sh ealth a m 27 is		Karen TRAC	y- Daughter	1979 ESHER C	t. For	est Hill	MA 21050
Physician Modical Examiner Developed Active Modical Examiner Due to (or as a consequence of): D	Jore	ige 1 an nt of Hu t: If ite or oth		1 Burial 2 Cremation 3	Removal from State		Date	20c. Location - C	ity or Town, State
Physician Modical Examiner Developed Active Modical Examiner Due to (or as a consequence of): D	altin	mit. Pa bartme bortani r injury			Jugin		10/19/2011 BCADE	J-ASKHON	MORE, MA
State State	Ä	any per		> Tuthukk	\supset	PA, 21344	11/0W S	Dring K	20ad 21283
Modical Examiner Modical Exa		.		shock, or heart failure. List only o	olications that caused the death. Do ne cause on each line.		_		Approximate Interval Between Onset and Death
State Sequentially late conditions Due to (or as a consequence of):		Medical		disease or condition	a. Due to (or as a consequence		Char		
IF FEMALE: 23b. Was decedent pregnant in the past 16 months? 23c. If yes, outcome of pregnancy 1		Examiner	¥	Sequentially list conditions,	b				
IF FEMALE: 23b. Was decedent pregnant in the past 16 months? 23c. If yes, outcome of pregnancy 1	V,	ted Insit	mine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):			
IF FEMALE: 23b. Was decedent pregnant in the past 16 months? 23c. If yes, outcome of pregnancy 1	Ma	execu ian and irial-tra	l Ex	that initiated events resulting in death) Last	Due to (or as a consequence	of):			
When the state of	092	cate be physic s the bu	edica		d				
When the state of	68	ending nuse as	an/M	23b. Was decedent pregnant		a 3 Ectopic pregnancy		23d. Date	of delivery
When the state of		e death the atte	ysici	in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of death			Mont	h Day Year
When the state of	P.O.	that the red by detac	y Ph		ontributing to death but not resulting	in the underlying cause given in Part I	23e. Dio	I tobacco use contrib	ute to the cause of death?
When the state of		quires en sigr ould be	ted b				1 [Yes 2 □ No 3	Probably Unknown
When the state of	Scor	law re has be ge 2 sh	mple				aut	topsy pri	or to completion of cause of
When the state of	al R	an: The tificate tor, pag	e Co	25. Was case referred to medical		26. Place of Deat	1 🗆 Ye		Yes 2 No
When the state of	Vita	hysicii his cer al direc	임	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3 DOA Other: 4 Nu		sidence 6 Other	(Specify)
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When the state of	/isio	r Atter ter dea rector	ertifi	3 Suicide 6 Could not b	e 28e. Place of Injury - At home, fa	rm, street, factory, office			or Rural Route Number,
When the state of	Ö	pital o	cal C	20a Certifier Certifying Phys		death occurred at the time, date and			ac etated
When the state of		he Hos in 24 h he Fun ipletely	Medi	(Check 2 Medical Exami	ner: On the basis of examination and/o	or investigation, in my opinion, death oc	curred at the time, date	e and place, and due to	the cause(s) and manner states
State 31. Date filed (Month, Day, Year) 32. Legistrar's Signature		To t		29b. Signature and title of certifier	100 Mar	29c. License number	19	29d. Date signed (Month, Day, Year)
State 31. Date filed (Month, Day, Year) 32. Legistrar's Signature		0/		30 Name and address of person who	completed cause of death (tem 23a) (Type, Print)		10114	1001
State		<u> </u>		H. Chando	n 617-54m	mers tu	C KD,	10a/10)	21221
Registrar JEC 2 2 2011 Down A. Agaile						parked			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>11</u> Month Physician/ 7:47 PM Robert Harry Meil Dec 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House Westminster If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday, 9. Rirthplace (State or Foreign Funeral Days Min. 1 XM 2 | F 72 216-38-4006 Director MĎ Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d Inside City Limits 10b. County 10c. City, Town or Location Director Carroll Westminster MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 USA 615 Woodside Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. þ 1 Never Married 2 XMarried 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 - Widowed 4 - Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Services Transportation Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ Carl J. Meil Sr. Ida Selvage 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Woodside Dr., Westminster, MD 21157 Linda L. Meil-wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State South Carroll Crem 12-22-11 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home Komas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician} hus 15 disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by to completed filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 Ao 1 Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2035 2011 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) Westminter MO 21157 HAUCO one

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me, 2922,12/16/2011dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCHOOLR **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Health + Kensh Ctx Baltimore Overlea Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 M 2 P Months Days Hours Pennsylvania 6-16-19 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or than "natural", or items 23a or 28a-f show Baltimore City 1 √Yes 2 No Director N/A MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code hours after death with 7411 Berkshire Road United States 21224 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕅 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Year or Dates: Completed by White 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any injury or other traumatic event, the Magonee. Elementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lula S. Ryland Raymond Moyer ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7411 Berkshire Road Baltimore, Maryland 21224 19a. Informant's Name/Relationship (Type. Print) Mr. George R. Murray (Son) 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp. 11/2/2011 Towson, Maryland 4 ☐ Qonation 5 ☐ Other (Specify) 21. Si natu of Funeral Service Licensee 22. Name and Address of Facility al Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SENSIS wk /Medical Due to (or as a consequence of): **Examiner** 1/w VEMMOVIA Sequentially list conditions, Physician/Medical Examiner any, leading to immedial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law req. ires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has beer signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burial-transit Parkinsoni Due to (or as a consequence of): Hazer II tartome Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by failure 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No trachure Bilateral 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 X Yes 2 100 Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury
Unknown
July, 2011 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1-Diatural 1 ☐ Yes 2 XNo Subject fell. **UNknown**^M 2X Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 500 Virginia Ave. Towson, MD, 6110 Belair Rd., Balto, MD 3 Suicide determined 4 ☐ Homicide Home & Nursing Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11-01-2011 Physician D0070832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Tregistral DEC 1 0

MOHAWWED

31. Date filed (Month, Day, Year)

KIDDUGAVU

32. Registrar's Signature

821 NEUTHW ST # 308 Baltimore MD ?

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			- State of Marylai - State of Marylai Registrar 23aPtI,II,25	per me,	g922 titicate	12/1	6/20 eath	11dhb	illai Hy	Reg. No.					
	Physicia		1. Decedent's Name (First, Middle, Last) Chester T. Maxwell						. Date of De Month		20,	3. Time of Death 9			
رعند	Medic Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death								4c. County of Death				
	<u> </u>		Franklin Square Huspital 5. Social Security Number 16. Sex 17. Age (In yrs.	last hirthday)	If Under 1	Sec.	If Under	24 Hrs p	8. Date of Birth 9. E			more thplace (State or Foreign			
	Funeral Director		411-44-4108 1 TXM 2 🗆 F	Yrs.		Days	Hours	Min.	(Month, Da)	y, Year)	Co	untry) MD			
	and show Lat	or	Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	cation							10d. Inside City Limits			
	Maryla 28a-f otifiec	irect	MD Baltimore	Ess								1 ☐ Yes 2X No			
	with the s 23a or ust be n	eral D	10e. Street and Number 448 Stemmers Run Road		10f. Zip 0	Code 2122	21				n of What Co ISA	ountry?			
1Cr 2036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates.		Vas Deceder f Yes, specifi 				y Yes or No- an, etc.)	1	Race - Ame Black, White ecify:				
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and	be filed ental H rked of ic ever	To B	17. Father's Name (First, Middle, Last) Chester T. Maxwell						First, Middle, Mae						
$\mathbb{M}_{\mathcal{U}} \times \mathbb{W} \in \mathbb{W}$ Baltimore, Mary	d 2 should alth and M 1 27 is mal er traumat		19a. Informant's Name/Relationship (Type, Print) Alice Ann Maxwell /wife								vn, State, Zip MD				
AXWE Imore, Mai	Page 1 an nent of He ant: If iten ury or othe	ķ.	20a. Method of Disposition 1 ◯XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Place of Dispo	sition (Name natory or oth EST	e of er place eme	ter	y 11/	21/1	20c. Locat 1 Fed	tion-City or leral:	Town, State sburg MD			
Balti	permit. Departr Imports any inji	7	21. Signature of Funeral Service License	2002		nne	11y	Fune	ral H	Home		to. MD			
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13	cate be executed physician and s the burial-transit	l Exar	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consecution of the consecution of th	quence of):		K	1		ED BY MEDICA	LEXAMINE					
760	cate be physicia the bu	edical	d			/ c	ERTIFICAT	ION APPLICA							
A. Box 68	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live Birth 2 □ Fee 4 □ Pregnant at time of 9 □ Unknown	tal death 3 🗌	Ectopic pro Other (spe	egnancy				- 1	d. Date of de Month	livery Day Year			
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Division of Vital Records,	The law req ate has bee page 2 sho	Completed by	Hypertension Dehydration						24a. Was autor perfo		prior to death?	topsy findings available completion of cause of			
ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1			Other		th (Check or							
of V	ng Physter this neral d	te: To	27. Manner of Death 1 ☑ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	28b. Time of injury		c. Injury work?	4 ∐ Nu		5 L Residue. Describe f		Other (Spec	<u>ify)</u>			
ision	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	2 \(\text{Accident} \) 3 \(\text{Suicide} \) 4 \(\text{Homicide} \) 4 \(\text{Homicide} \) 5 \(\text{Pertiting} \) 6 \(\text{Could not be determined} \) 6 \(\text{Could not be building, etc. } \) 7 \(\text{Special in the could not be building, etc. } \) 7 \(\text{Special in the could not be building, etc. } \) 8 \(\text{Special in the could not be building, etc. } \)	nome, farm, stre	M eet, factory,	1 🗆 ነ	∕es 2□	-	f. Location (\$ City or Tow		umber or Ru	ral Route Number,			
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	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	(Check conly one) 3 Certifying Nurse Practitioner: To the best of	on and/or invest	tigation, in my	y opinior	n, death oc	curred at the	e time, date a	and place, an	d due to the	cause(s) and manner stated.			
	To t To t		29b. Signature and title of certifier		29c. I	License	number				igned (Monti	*			
	6		30. Name and address of person who completed cause of death (Itel	m 23a (Type, P	Print) Vankli	N 6			ve 7		1-16-2	21237			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 4:45 P M 2011 December Augusta McNeely Susan Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery National Lutheran Home Rockville g. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. Social Security Number **Funeral** Min Days Hours Year 931 1 🗆 M 2 🖾 F 1th 1 Day, Tilinois Yrs Dec 80 **Director** 483-34-8400 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 X No 28a-f Kensington Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code ō 10e. Street and Number Funeral 23a United States 9805 Hillridge Drive 20895 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give ò þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aid Education Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hy Important: If item 27 is markany injury or other. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bessie Boots Jens B. Jensen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Blackberry Ridge Dr. Aurora, IL 60506 Ste<u>ven</u> K. Messerli 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Journey Crematory 12/23/2011 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signat of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the burial Physician/Medical Box 68760 IF FFMALE: use 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Day Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de by 1 ☐ Yes 21 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 1 No ER/Outpatient 3 DOA ဂ္ 1 Yes 1 Inpatient 2 I Wall Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier 29c. License number

State Registrar

Charles W. Karesh 26033 Ridge Road Damascus,

08

31. Date filed (Month, Day, Year)

DEC 2 2 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 20872

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 9:30 Ruth Beard Marsh December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Collington Nursing Home, Arbor Unit Bowie If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) If Under Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Director 444-32-8737 1 M 2 X F 79 June 30, 1932 Oklahoma Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 X No Maryland Prince George's Mitchellville 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 10450 Lottsford Road, #122 20721 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify. Specify: Caucasian 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Homemaker Own Home 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental | မ William David Beard Virginia Inez Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health William Harrison Marsh/Husband 10450 Lottsford Rd #122 Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important; If ite any injury or ot . Page 1 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 12/21/2011 Woodbine, Maryland Final Signature of Funeral Service Lic Coing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 125cular WEGES Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?

1 Yes 2 No Pregnant at time of death Linknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by holeastitis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 No page 2 No over ovancin 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury affer death.

Director Aft
d in by the fur 1 Yes 2 No M Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) filled in 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Records, P.O. Box 68760 Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Turse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/30/3011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12158 Central Ave NICLIAM 31. Date filed (Month, Day, 32. Registrar's State DEC 2 2 2011 Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Hyacinth McMorris December 2011 3:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) 579-62-7005 **Director** 1 🗆 M 2 🔀 F 92 July 11, 1919 New York 28a-f shov with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No DC Washington DC 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? Funeral 23a 2939 Van Ness Street NW 20008 United States or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married 1 Yes 1 2 🗶 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 'natural", eted 3 Widowed 4 Divorced Black Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Accountant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည injury or other traumatic Terrence Villers McMorris Lily Mae Stewart 1 and 2 should be the Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philipa Duncker / Guardian 13 Amy Ct. Eastampton, NJ 08060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or otl once. Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Journey Crematory 12/22/2011 4 Donation 5 Other (Specify) Woodbine, Maryland Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M UNNUAMO1251 MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Multi-infarct Dementia disease or condition Medical resulting in death) **Examiner** Cerebrovascular Disease Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury g physician and as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Day Pregnant at time of death 5 Other (specify) Yes Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 perform 2 🗌 No Yes 2X N 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛮 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Funeral hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

DEC 2 2 2011

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bindu Joseph 1160 Varnum St. Washington DC 20017

D60634

December 18, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 17, 2011 11:26 AM Ruth Mae McGrady Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Darlington 2222 Castleton Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV • 9, 1940 Social Security Number 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Months Days Hours Country Maryland 71 Director 212-50-4202 Nov. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21034 2222 Castleton Road "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 9 Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes Give Completed 3 XWidowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Hame Homemaker Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Edna Mae Elliott James Vinton Cullum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Aberdeen Avenue, Aberdeen, Maryland 21001 Connie Tuleck / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Bel Air Memorial Gdn 12/21/2011 1 X Burial 2 ☐ Cremation 3 ☐ Remo Bel Air, Maryland 4 Other (Specify) re of Funeral 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sign 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ Medical resulting in death) Examiner Securially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last burial attending physician for use as the buríal Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Records, 1 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed 1 Yes 2 No certificate Yes **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: 1 🔲 Yeş 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 4 Nursing Home 5 X Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes Certificate: 28d. Describe how injury occurred After iniury **V** Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director. / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Fractioner. To the contest of my knowledge death occurred at the time date and place, and time remarks at the remarks at the countries of t 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE ATRIUM VILLAGE OWINGS MILLS 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Min. Director 216-48-0346 1 M 2 X F 64 02/17/1947 MD Usual Residence of Decedent or 28a-f show the Maryland at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director s 23a or 28a-f shust be notified a 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral filed within 72 hours after death with Hygiene. other than "natural", or items 23s rent, the Medical Examiner must I 4730 ATRIUM COURT 21117 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education cify only highest grade completed, 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene, Important: If frem 27 is marked other that any injury or other traumatic event, the 1 once. CLERICAL SOCIAL SECURITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 BEN WASSERMAN MILDRED CHENKIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL WASSERMAN / BROTHER 1909 SPANN STREET, HOUSTON, TX 77019 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖁 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CEMETERY CHIZUK AMUNO CONG. 12/21/2011 BALTIMORE, MD Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause out at hine. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last led by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death ☐ Yes 2 ☐ No detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be sign 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed? Yes 2 No has page 2 certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital <u>P</u> Other: 1 TYes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending work? 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi OV

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death BEATRICE McDANIEL DECEMBER 20, 2011 Physician/ MARY 2:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE STELLA MARIS HOSPICE CENTER TIMONIUM If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 215-22-3774 87 **Director** 1 M 2 X F 1-4-1924 MARYLAND Usual Residence of Decedent 28a-f show at 10c. City, Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified BALTIMORE ROSEDALE 1 🗌 Yes 2 🛣No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral **23**a 7933 OAKDALE AVENUE 21237 U.S.A. , or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", WHITE Completed 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene, marked other than Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) WIRE AND SOLDER WESTINGHOUSE Be Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any oriant or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ျ MUNSON SALVATORE MOCERE ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21237 7933 OAKDALE AVENUE ROSEDALE, MD GLENDA HOCK/DAUGHTER Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 🗌 Burial 2 🗷 Cremation 3 🗆 Removal from State 12-22-11 CATONSVILLE, MD METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME Signature of Funeral Service Licensee ROSEDALE, MD 21237 1211 CHESACO AVE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ACUTE RENAL DISEASE Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed Yes 2 X No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Division 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month) Day, Year) 29b. Signature and title of certified MSO 711158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

TRACIE L. MORGAN, CRNP

DEC 2 2 201

31. Date filed (Month, Day, Year)

D.III

2:40

2011

DECEMBER

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 17, per fh. g922 12-29-11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20, Marie Musson December 2011 7:50 РΜ Joan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery 4422 Judith Street Rockville Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Mir (Month, Day, Year) 214-36-2630 Director 1 M 2 X F August 10, 1939 Maryland 72 Usual Residence of Decede 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 Yes 2 X No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? must be Funeral **23**a 20853 4422 Judith Street United States items be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Medical Examiner Armed Force Black, White, etc. ŏ þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White "natural" 3 X Widowed 4 Divorced Completed Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. မ Charles E. Watkins -Charles E. Musson Mary Belle Hawkins and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4424 Judith Street, Rockville, Maryland 20853 Larry E. Musson Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December Page 1 Upper Seneca Baptist Church Cemetery 1 X Burial 2 Cremation 3 Removal from State Germantown, Maryland 4 Donation 5 Other (Specify) 27, 2011 Signature of Funeral Service Licensee

Mysefette Daynes 22 Name and Address of Facility Funeral Hore/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 Years Immediate Cause (Final Physician/ Hypertension disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Unknown Seizure Disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last iding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Depression, Anxiety Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? 1 Yes 2 No Yes 2 X No **Division of Vital** filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 X Yes 2 □ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) December 21, 2011 R096053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15245 Shady Grove Road, Rockville, Maryland 20850 Babette Pennay, CRNP 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

32. Registras's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 41099 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Docember Dayy Physician/ 2011 Ardella Milton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Co. Hanover Baltimore Washington Center 6. Sex If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min 1 □ M 2 🛶 04910711931 Marviland 80 **Director** 216-28-6375 Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director must be notified 1 🗌 Yes 2 🔀 No Severna Park MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? ò 10e. Street and Numbe items 23a Funeral U.S.A. 37 Hills Rd. 21146 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 XWidowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Gene's Grocery 6th Grade Cashier other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mabel Unk Charles Williams Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tra-1478 E. 15th St., Jacksonville, FL. Michael Snead(nephew) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) on-site Crematory 12/21/11 Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home MD21217 2140 N. Fulton Ave., Baltimore, Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death erebrovascular Immediate Cause (Final ccidem Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of). **Examiner** an Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying and -transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death the 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 1 မ Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Man ar of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural work?
1 Yes 2 No n 24 hours after death.

e Funeral Director: Aft eleted filled in by the fur Investigation 2 Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 17,1 29c. License number 29d. Date signed (Month, Day, Year) Nvpe, Print) 30. Name and address of person who

State Registrar

Registral Liberty

Seovae t

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:45A M **JAMES** FRANCIS O'BRIEN DECMBER20, 2011 Medical 4a, Eacility Name (if not institution, give street and number)
SAINT JOSEPH MEDICAL CENTER **Examiner** 4b. City. Town, or Location of Death BACTIMORE TOWSON Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 213-32-1227
Usual Residence of Deced **Director** 1 👿 M 2 □ F 77 June 14, 1934 Maryland 28a-f show be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified N/A 1 X Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 6206 Mossway 21212 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 7-60
If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 4 Vice President/Executive Banking event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked ot ir other traumatic ever မ Arthur Seymour O'Brien Helen. Kelly t. Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie D. O'Brien 6206 Mossway, Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1
Burial 2
Cremation 3
Removal from State Department or Important: If any injury or once, 0 Green Mount Crematory 12/27/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signa Me gr Fureral South Thomas Martin D. Lawson MYTCHETTEN EDEFELD FUNERAL HOME INC 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION Phonician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day been signed by the a g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 3 Probably 4 Unknown 1 Tes Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2X No death? certificate 1 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No ျ 1 Inpatient 2 X ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) Director; After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 🗌 No 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D62312 December 20, 2011 are rson who completed cause of death (Item 23a) (Type, Print) V 7 ROBERT SCOTT BRANNAN, M.D. 7601 OSLER DRIVE TOWSON, MD

State Registrar

31. Date filed (Month, Day, Year)

DEC

2 2011

DHMH 17 Rev 06-2011

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RAYMOND PATRICK OWEN DEC 15 2011 4:39 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MONTGOMERY BETHESDA WRNMMC Social Security Number 7. Age (In vrs. last birthday) If Under Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 M 2 D F Funeral Cou/Webraska Months Davs Hours Min 472971946 65 512-44-7505 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tes 2X No VΑ Gloucester Gloucester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 5298 Hickory Fork Road 23061 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. 1974-1993 Specify: Caucasian "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Communication Elementary/Seconday (0-12) College (1-4 or 5+) Operations Chief Military Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Darlene Payne Walter Owen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5298 Hickory Fork Rd., Gloucester, VA 23061 Dobrila Owen /Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Alberty, Comator Horitolece)
Memorial Veterans 1 X Burial 2 Cremation 3 Removal from State Suffolk, Virginia 12/22/2011 4 ☐ Donation 5 ☐ Other (Specify) Bethesda-Chevy 21. Signature Fureral Service Licensee Robert A. Pumphrey Funeral Home Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC LUNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Universitying Cause (Disease or iinjury Due to (or as a consequence of) burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page 2 s certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 🗷 No မ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After work?
1 Yes 2 No injury 1 X Natural 5 \square Pending n 24 hours after death.

Funeral Director: Afte bleted filled in by the fun Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a 29c. License number 29d, Date signed (Month, Day, Year) 2011 0101231164 'X' dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and WRNMMC BETHESDA MD 20889-560 AVE. JOE1 NATIONS 8901 WISCONSIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 16, 2011 3:53 P M Stephen Omar Piranti Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Director 088-62-0259 1 🗶 M 2 🗆 F Yrs June 22, 1978 New York 33 Usual Residence of Decede 28a-f show 10a. State 10b. County the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland| Hyattsville Prince George's 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral with 23a 505 Chillum Road #202 20783 United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mulonce. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 X Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mover Movina Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sharon E. Simmington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Washington / Sister 7100 Sunrise Dr. Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Final Journey Crematory 12/22/2011 Woodbine, Maryland 21. Signature of Funeral Service Lic Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CARDIAL Physician, 73005 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 2154456 (ORONARY Jar Tray Sequentially list conditions, if any, reaung to immediate cause. Enter Underlying Lue to (or as a consequence of) Exami CONGESTIVE (TEANT Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year s been signed by the should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy death? perform certificate 1 🗌 Yes 2 🗌 No 2 N 1 🗌 Yes Division of Vital director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) 2 🗌 No မ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 Inpatient 2 KER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year) N04495 DECEMBER 18 of death (Item 23a) (Type, Print) 30. Name and address of person who completed Randall P. Wagner 7600 MD 20912 <u>Carroll</u> Ave Takoma Park, 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 2 2 2011 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2. Date of Death

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Year

1 - State of Maryland / Department of Health and Mental Hygiene per me, g922, 12/19/2011 dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ Mar Month ekars 7.011 Jecembe 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Elizabeth Rehab n/a Center timor If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Security Number 8. Date of Birth Funeral (Month, Day, Yea 3/2/1918 Maryland 1 M 2 X F Months Days 218-05-0352 93 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehrmany injury or other traumatic event the state of 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21227 3308 Benson Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lorretta O'Conner Joseph Putgenter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Road, Centreville, Maryland 21617 Carey A. Piekarski / Son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/7/2011 Donation 5 Other (Specify) Meadowridge Mem. Pk Elkridge, Maryland 22. Name and Address of Facility Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, men disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury mi After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): DN APPROVED BY AMEDICAL EXA Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 CERTIFICA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Yes 2 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 8c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 🛕 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar					ertificate				Reg. No	201	41101
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Examin				ve street and number)	776A V	, Jun			ocation of Death		4c.	County of Deat	in Limore
Funeral		Social Security N	umber 6.	Sex 7. Ag	je (In yrs. la	ast birthda	y) If Under 1		If Under 24 Hrs. Hours Min.	8. Date of Birl	h v. Year)	9. Bir	thplace (State or Foreign
Director		212-82-3 Usual Residence of		TAJ W Z L F		79 Yrs	s.			(Month, Da 04/15/	7193	2	UKRAINE
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the Ma a or 28¢ be notif		MD 10e. Street and Nur	BALTIN mber	10KE	TU	WSON	10f. Zip C	ode			10g. Cit	tizen of What Co	puntry?
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after de ", or ite amine	by	1 🗌 Never Marr	ried 2 X Married	Armed Forces?			If Yes, specify	Cuban,	Mexican, Puerto	Rican, etc.)	1	Black, Whit	e, etc.
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amprotant: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho amply injury or other traumatic event, the Medical Examiner must be notified at anote.			Cremation 3	Removal from State	, 0	emetery, o	sposition (Name crematory or othe	er place)	:	Date 1 / 2 0 1 1		ocation - City or	
permit. Page 1 al Department of H Important: If itel any injury or oth		21. Signature of Fu			DAL.	TIMOR	22. Name and			DL LEVIN			TOWN, MD, INC.
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xecuted n and al-trans	Examiner	Cause (Disease or that initiated event resulting in death)	s	c. Oblist Due to (or as	$\overline{}$	-	entilay	700	Sy nar	ome.			years
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Vithir Vithir Comp	_	29b. Signature and	title of certifier	47 /		2.4.4		icense r				ate signed (Moni	
1.7		30. Name and addr	ress of person wh	o completed cause of	death (Item	23a) (Typ	pe, Print)	KO:	11104		10	X/11/2	0//
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Derembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4 Hrs Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Hours Country) Director 1 □ M 2 🔽 92 28a-f show 10d. Inside City Limits at 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director must be notified 1 Wes 2 □ No 10g, Citizen of What Country? 0 Of, Zip Code Funeral items 23a USA 21237 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14 Bace - American Indian 11. Marital Status 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Lite "natural", 3 ☑ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOME Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H, Important: If item 27 is marked any injury or care 17. Father's Name (First, Middle, Last) ပ 1cholas 19b. Mailing Address (Street and Number 08 20c. Location - City or Town, State d of Disposition 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or 12011 Bradley - ASKLON FUNERAL HOME 21. Signature 21232 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Schemic MACS disease or condition Medical resulting in death) to (or as a consequence of): **Examiner** Sequentially list conditions, it any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery was deceue.
in the past 18 month
Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Day Month Pregnant at time of death 1 Yes 2 the P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? has page 2 certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မ within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 2 Accider 5 Pending 1 Yes 2 No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check a title of certifie 29d. Date signed (Month, Day, Year) 29b. Signatyre 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

homas Rooks		- For State	ate of Maryl			ent of l		and	Menta	l Hyg		eg. No.	20		41106
Physician Medical Examine	1	egistrar Decedent's Name (First, Middle Thomas Rooks	e,Last)								Date of Dea	nth Day er 18, 2011	/ear	164	of Death
	4	la. Facility Name (if not institution 1624 W. Saratoga Str	eet				City, Tow	e				4c. Coun	r	ı/a	
Funeral Director		5. Social Security Number 213–62–3105	6. Sex	7. Age (In y		hday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.		rth(MM/DD/YY 2/1955	Fore		
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5-0036 Hours after the within 72 hours after the wither than "natural", the Medical Examiner	mpiered	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12	College	1-4 or 5+)		Decedent's during mos	st of workin	g life. D	O NOT us	e retired	1)	Feder	ral (
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Baltimore, permit. Pages 1 ar Department of Her Important: If ite		Dorration 5 Other Signature of Funeral Review	icertee		•	Joh 451	me and Ad n L. 7 Par	dress o Wil k He	facility liams eight	Fur	neral ve Bal	Owing Directo	ors,	P.A.	
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Box 68760, e death certificate be extending physician ed for use as the burial -		UNPENDED IF FEMALE: (3b) Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	ne 1 Live	, outcome of birth gnant at time	- f - +	2 Feta	al death er (Specify	3 [Ectopic p	pregnand	cy	23d. Date Monti		ery Day	Year
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Division of Ta the Hospital or Attending Phwitin 24 hours after death. To the Funeral Director. After completely filled in by the funeral	Certification: 1	2 Accident Inve	ding FOUN Dec 16	e of Injury th, Day,Year) D: 3, 2011 ace of Injury -	FO 164	Time of In UND: 5 hrs		I ☐ Ye	at Work? es 2 ✓ N	v₀ S	ubject inf	e how injury oc naled carbo (Street end Nu	n mon		imes
Divisior To the Hospital or Attend within 24 hours after death To the Functal Director; completely filled in by the		4 Homicide 29a. Certifier 1 CertifyIng F	rmined (Specification)	Rowho	use wledge, de	eath occurr	ed at the ti	me, date	e and plac	e, and d	or Town, 624 W. Sa ue to the ca	State) ratoga St., Ba	altimore	, MD tated.	
To the within To the comple		2 Medical Example 299. Signature and title of certification	mD.	stated.			29c. l		number	urred at	the time, dat	29d. Date :	signed (i	Month, Da	
H		30. Name and address of person Laron Locke MD. A 31. Date filed (Month, Day, Year,	Assistant Medic		ner 90	0 W. Ba		Street,	Baltime	ore, M	D 21223				
Sta Registr		ÜEC 2 2 201	1 Bear	a B	. 40	arker									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11:25AM **Physician** Mae U.C. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Montgomer 2601 Glenn If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth | Months | Days | Hours | Min. | Month, Day, Year) Birthplace (State or Foreign Country) Vi Gima 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 1 M 2 F 223-56-5770 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if then 27 is marked other than "natural" or item. or any injury or other traumatic 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Thes 2 TNo **Funeral Director** 4aryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 260 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) (reneval 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nannie Dunn Keavis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3386.7 19a. Informant's Name/Relationship (Type. Print) Lawrenceville Kose Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Grove Church Cem. Lawrenceville Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Par Home 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as carpiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Budiomy **Physician** 2004 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Cando 10ait 2 No 1 □ Yes 2 🗆 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.O. Box 68760, Division of Vital Records.

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jeer919

30. Name

313

DHMH 17 Rev 1/2001

Silver

29c. License number

29d. Date signed (Month, Day, Year)

20902

2011

and manner stated?

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

Ane

				Type or F #20b&c State of	Print in E Per FH Marylan	Black In G923 Id / Depa	delible In 1/04/20 artment of	k. Ensure A	II Copies Mental Hy	Are Legiene	gible.	1.1108
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1	/Medic		Annie Mae Richar				41. O't. T	and anation of Dooth	12	11	2011 nty of Death	1310
	Examin	er	4a. Facility Name (If not institution, gi				-	n, or Location of Death Spring	1		gomer	
			Genesis Fairland 5. Social Security Number 6.		7. Age (In yrs.	last birthday)	If Under 1 Yea	ar If Under 24 Hrs.	8. Date of Bir		_	place (State or Foreign ntry)
	Funeral Director			1□ M X □ F	96	Yrs.	Months Day	ys Hours Min.	8. Date of Bir (Month, De 02 15	ay, Year) 5 1915		GA
	yland Jow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	a-fst	ctor	DC		Ţ	Vashing	gton					1 □X es 2 □ No
	or 28	Dire	10e. Street and Number				10f. Zip Cod			10g. Citizen	of What Cou	ntry?
	ath w	la l	909 Longfellow			0 10	20011		nocify Voc or No	USA	Race - Amer	ican Indian
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Deatlest Exp. it art rutal to conflined at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	ces? 2 🙀 No e		was Decedent of the state of t	of Hispanic Origin? (S cuban, Mexican, Puert No <i>Specify:</i>	o Rican, etc.)		Black, White,	etc.
5-0	72 ho natur fical	eted	15. Decedent's E (Specify only highest g	Education rade completed)		(Give	dent's Usual Oc kind of work do	ne during most of wor	king	16b. Kind o	f Business/li	ndustry
21	ithin ne.	Completed by	Elementary/Secondary (0-12)	College (1-	-4or 5+)		DO NOT use re ceeping	tired)		House	keepi	nø
2	Hed w		17. Father's Name (First, Middle, Las			nouser	ceeping	18. Mother's Nar	ne (First, Middle			
ano	d be fi	Be c	Unknown	"'/				Mamie	Collins			
Maryland	1 and 2 should be filed vealth and Mental Hygii em 27 is marked other other traumatic event, II	2	19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ng Address (Str	eet and Number or Ri	ural Route Numb	ber, City or To	wn, State, Z	ip Code)
S	nd 2 salth al		Johnny Richardso			1		llow St. N				
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition		20b.	Place of Dispo	osition (Name of patory or other	place)	Date		on - City or I	
E	Page nent c int: If	li	1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		State Ma	tional	Memoria	al PK 12/		Fall:	- Chur	ch, V A
alti	permit. Pages 1 Department of H Important: If ite any injury or of once.		21. Signature of Fungral Service Lice	ensee				ddress of Facility Ma				
_	63 E # 9		put Colm	dera	_			n St. NW W			2001	
	Physician /Medical Examiner		23a. Port 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a. Car	diac A	rrthym: quence of):			c or respiratory	arrest,		Approximate Interval Between Onset and Death instant
		ě	Sequentially list conditions,		or as a conse							
68760,	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, bearing to thin solution cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec	quence of):						
P.O. Box 6	The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown		oirth 2 ☐ Fet nant at time of	al death 3	□ Ectopic pregr □ Other <i>(specif</i>				. Date of del Month	Day Year
ν. Τ	s that med t		Part II. Other significant conditions			sulting in the u	inderlying cause	e given in Part I.				the cause of death?
rds	quire en sig uld bi	q pa	Congestive Hear	t Failur	e				1 🗆	Yes 2 1	√lo 3∏Pr	obably 4 🔀 Unknown
Records,	To the Hospital or Attending Physician: The law requires that the de within 24 hours are reash. To the Funeral Director After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed by	Chronic Kidney	Disease		b			per	s an 2 opsy formed? 2 🖾 No	prior to death?	itopsy findings available completion of cause of 2 🖾 No
Division of Vital	sian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only	one)		
¥ \	Physician: r this certific ral director, I		1 ☐ Yes 2 ☑ No		Inpatient 2	1			Home 5 ☐ Re			cify)
ū	ing P	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	1 '	of Injury th, Day, Year)	28b. Time o Injury		Injury at Work?	28d. Describe	e how injury o	ccurrea	
Sio	teach tor / the f	Certification: To	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be Occ Diago	of Injuny - At I	nome form st	reet, factory, off	1 ☐ Yes 2 ☐ No	28f Location	(Street and N	lumber or Bi	ural Route Number,
Ξ	or A	artif	4 ☐ Homicide determine		ing, etc. (Spec		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100	City or T	own, State)		
_	Hospital 24 hours Funeral stely filled	Medical Co	29a. Certifier 1 Certifying (Check only one)	aminer: On the b	best of my kreasis of examir	nowledge, dea	th occurred at t nvestigation, in	he time, date and place my opinion, death occ	ce, and due to the curred at the time	ne cause(s) ar e, date and pl	nd manner a ace, and due	s stated. e to the cause(s)
	o the ithin o the omple	Mec	29b. Signature and title of certifier	and man			29c. Li	cense number		29d. Date s	signed (Mont	th, Day, Year)
	F > F 8		COALA-				D2	8656		12/15	/2011	
			30. Na read Holls of person wh	no completed caus	se of death (Ite	em 23a) (Type						
			Ravi Passi, MD	1524	5 Shady	Grove	Rd. #1	30 Rockvil	lle, MD	20850		
	Sta	ate	21 Date filed (Month Day Vear)	32 F	kar's Sign	nature						
	Regist	rar	DEC 2 2	2011	enema	1. 4	backer					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state of Maryland / Department of Health and Mental Hygiene me. 922, 12, 16, 2011 dhb Registrar

State of Maryland / Department of Health and Mental Hygiene me. 922, 12, 16, 2011 dhb
Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 1:05 PM NOV Mary Elizabeth Reynolds 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITKI BALTIMORE AGNES If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Min (Month, Day, Year, Ct. 13, West Virginia Yrs 1935 Director 212-36-2717 76 Oct. Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits notified at Baltimore Maryland Halethorpe 1 ☐ Yes 2√XNo 10e Street and Number 10f. Zip Code 5 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 21227 1140 Gloria Ave. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 9 1 Never Married 2 XMarried à Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be flied within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own home injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victor C. Via Roxie E. Lockhart permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bill Reynolds / Husband 1140 Gloria Ave., Halethorpe, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park Nov. 29,2011 Elkridge ,Maryland 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. uneral Service Licensee 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASPIRATION Onset and Death Priysician/ MINUTES disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) EXAMINER nding physician and use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or linjury ON APPROVED BY M that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Records, P.O. Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No Division of Vital 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 🗶 No Certificate: 28d. Describe how injury occurred Hospital or Attending 5 Pending Natural 11/24/2011 n 24 hours after death.

e Funeral Director: Afte beted filled in by the fun **Unknown**_M Unknown 2 Accident
3 Suicide
4 Homicide Investigation 6 K Could not be 28f. Location (Street and Number of Rural Route Number, City of Town, State) 900 S. Caton Ave. Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office determined Hospital Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuing Nurse Practionar To the basis of my investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 24 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH CATON AVENUE, BALTIMORE, MD, 21229 KATHERINE 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 1 6 2011 Registrar

State of Maryland / Department of Health and Mental Hygiene per me,g922,12/19/2011dhb.
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23127 M lizabeth Reckline 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manylend Medical Conte n/a Baltmore niversity If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign Social Security Numb 8. Date of Birth **Funeral** Maryland 1 □ M 2 🔀 Davs Hours 2 / 17 19 45 66 218-42-5505 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he motified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1741 Wilkens Avenue 21223 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces? Black White etc þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Book Bindery 0 Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sally Trickett George Reckline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son William A. Reckline, Sr. 1917 Deering Avenue, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Baltimore, Maryland Ponation 5 Other (Specify) 11/4/2011 Bayview Crematory e of Funeral Service Lige 22. Name and Address of Facility Hubbard Funeral Home, Inc. Signati 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Sibargunoid Onset and Death Immediate Cause (Final Physician/ 3 garya disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) CALEXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed CATION APPROVED BY use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 ed by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown 24 hours after death.

9 Funeral Director: After this certificate has been signed by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension Were autopsy findings available prior to completion of cause of autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 Ho Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2

To the F only one) 29d. Date signed (Month, Day, Year) 101706 11/1/201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Hersh MD Baltimore MD 31301 Greene Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 25 State of Maryland / Pepartment of Health and Mental Hygiene Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November Day 0, 2011 Physician/ 10:38р м Marion E. Rolfe Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore St. MArtin's Home Catonsville 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 04°nth 42'19'21 Maryland 90 215-05-4177 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic average. 10c. City, Town or Location 10a. State 10b. County Director 1 X Yes 2 ☐ No Md. Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21224 911 South Clinton Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð 1 ☐ Yes 2 ➡ No Specify: If Yes, Give Specify: White 3 😾 Widowed 4 🗌 Divorced Completed Year or Dates. 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 2 Sarah Horney <u>James A. Reagan</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3108 Elliott St. Baltimore, Maryland 21224 Sarah Yourik (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Middle River, MD Donation 5 Other (Specify) Holly Hill Cemetery 11-15-2011 22. Name and Address of Facility
Hubbard Funeral Home, Inc ature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final EMORRHA Pnysician/ aus disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence oi). the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ASPIRATION and/or HOSPITAL CARE ACQUIRED 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown PREUMONIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? AO RTIC autopsy performed has TPERTENSIVE I DIABE 2 No certificate ☐ Yes 1 L Yes DISCUSE To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 000 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျ After this 27. Manner of Death 1 D Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 28a. Date of injury (Month, Day, Year) injury work?
1 Yes 2 No 5 \square Pending Accident
Suicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signaturejand title of certifier D0018362 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Koma 31. Date filed (Month, Day, Year)

9

. Registrar's Signature

Kens Ave Ste LIO.

Ma21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AMUEL Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Hours (Month, Day, Year) **Director** 554-50-6081 1 🗶 M 2 🗆 F 11/19/1921 CA 90 Usual Residence of Decedent Show 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location with the Maryland notified at Director 28a-f 1 Yes 2 X No LA JOLLA CA SAN DIEGO 10f, Zip Code ms 23a or ō 10e. Street and Number 10g. Citizen of What Country? Funeral 7887 LOOKOUT DRIVE 92037 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Completed 3 X Widowed 4 Divorced WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ MEDICINE PHYSICIAN of Health and Mental Hygie If item 27 is marked other is other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HYMAN RAPAPORT BERTHA KRUPNICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 998 SPRINGDALE ROAD NE, ATLANTA, GA 30306 DR. MARK RAPAPORT / SON Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CAMINO MEM. PARK 12/20/2011 SAN DIEGO, CA 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EREBRAG disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and use as the burial-trai Due to (or as a consequence of): attending physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

Funeral Director: After this certificate has been signed by the attending naturalism. Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Yea Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has autopsy Yes 2 No 1 Yes 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and til 29c. License number ne and address of person who completed cause of death (Item 23a 20V

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Dec. Richie Landen James 12:10 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 7208 Fait Avenue Baltimore City N/A If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours **Director** 1 🛛 M 2 🗆 F 218-87-3689 Usual Residence of Deceder 1 May 8,2010 Maryland show 10a. State 10b. County the Medical Examiner must be notified at 10c. City. Town or Location 10d Inside City Limits Director 28a-f N/A Baltimore City Yes 2 No MD 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? Funeral 23a 21224 United States 7208 Fait Avenue items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. ò þ 1 X Never Married 2 ☐ Married 🗌 Yes 2 🌠 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Dependant event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ Department of Health and Ment. Important: If item 27 is marked any injury or out. Angel M. Sweetsir Anthony P. Richie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland Mr. Anthony P. Richie (Father) 7208 Fait Ave. saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Holly Hill Mem. Gdns. 12/23/2011 Middle River, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Wichas 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ ASPIRATION PNEUMONIA WEEK disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner GASTRO ESOPHAGEAL REFLUX DISEABE 12 MONTES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examir burial-transi physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death Unknown 2 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, CONGENITAL HYDROCEPHALUS 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of ANOXIC BRAIN INJURY 24a. Was an autopsy performe death? after death.

Director: After this certificate PREMATURE BIRTH CHRONIC LUNG DISEASE 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes 2 🗌 No filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated e and title of certifier Stutter M) D0031002 DECEMBER 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANCY HUTTON JOHNS HOPKINS HOSPITAL, 200 NORTH WOLFE STREET, BALTIMORE, MD MO 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 3:05 AM December 201 Virginia Diane Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Min. Days Hours **Director** 214-48-1149 1 M 2 X F 07/30/1950 Tennessee 61 Usual Résidence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Middle River MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21220 U.S.A. 31 Cedar Drive, Apt. Α Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 X Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail 12 Security I Hygien other tl Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd Mental ⊢ marked of ၉ Miller Ramona Marie Woodrow Royal Clarence 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Cedar Drive, Apt. A, Middle River, MD 21220 Amanda Mesick / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any injury or ot Page 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/21/2011 Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lensee Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock, or heart failure. List only one cause on each line Immediate Cause (Final Dulmonary 06Structure Ph_sician/ years monic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Que to for as a consequente of: Examine rany, leading to immediate cause. Enter Underlying Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s has autopsy autope, performed? 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence De Other (Specify) No. 2014 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: To the Hospital or Attending injury 5 Pending 1 Natural s after death.

I Director: Af
od in by the fu Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled in within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 and title of certifier 29b. Sign 58303 and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES Change 50 TOUSON MO MON W 6701 Registrar's Signature 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Fasure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ali Sharafart 4:55P December 2011 2 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Randallstown Season's Hospice If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 45 217-65-4538 Director 1 🕅 M 2 🗆 F 66 Pakistan 03 02 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town Windsor Mill 10d. Inside City Limits with the Maryland 10h County must be notified at Director 1 Yes 2 No Baltimore MD Baltimore 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21244 U.S.A. 7113 Rolling Bend Road items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other ***- any injury or other traum***-Examiner Black White etc. þ 1 Never Married 2 X Married 1 Yes 2 X No Specify: Asian Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed Unemployed 12th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Hanifa Begum Rahmat Ali 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ali Marie Ct, Baltimore, Md 212144 Nadeem Butt-Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 12/26/2011 Rawalpindi, Pakistan 4 ☐ Donation 5 ☐ Other (Specify) Gha Signature of Juneral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Av olo Baltimore, Md 21215 Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between End-Stage Liver Discuse Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the ail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 24 hours after death.

Funeral Director: After this certificate has To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 other Specify hospice မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ns RajapaineM.D 00057465 12/22/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 3 W. S. Rajapakse, M.D. 2835 Smith AV 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

11-09494 Jeffrey Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # State of Maryland Department of Health and Mental Hygiene 1- For State Certificate of Death Rea, No Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 17, 2011 2247 hrs **Medical Examiner** Jeffrey Smith

4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore** Johns Hopkins Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Foreign Country) Months Hours Min Days Director 10/23/1979 32 216-27-8139 1 X M 2 F Yrs MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 9 10a. State 10b. County MD 1 X Yes 2 No N/A Baltimore filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number Kitmore 10f. Zip Code 21239 · Road USA 1278 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Never Married 2 Married Yes Black If Yes, Give Year Yes 2 No specify: Specify: 4 Divorced 3 Widowed <u>۾</u> 16a, Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Hygiene. d other than " t, the Medical Self Employed Home Improvement MD 21215-0036 N/A 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brenda Annette Richardson Pages 1 and 2 should be filment of Health and Mental Faot: If item 27 is marked or other traumatic event, Be George Whalen Smith and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kitmore 1278 Ketmore Road Baltimore, MD 21239 19a. Informant's Name/Relationship (Type, Print) Brenda Richardson- Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Randallstown, MD 12/23/2011 Department o King Memorial Park 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East 1101 E. North MD 21202 Baltimore, Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate ne cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED **AMENDED** the attending physician ed for use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Year 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has director, page 2 s performed' death? 1 🗸 Yes ✓ Yes 2 No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other: DOA 1 Yes 2 No 28a. Date of Injury (Mouth, Day, Year) Dec 17, 2011 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death Certification: Subject shot Natural 2204 hrs 1 Yes 2 ✔ No 5 Pending death Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 3 Suicide 6 Could not be or Town, State) 4200 Nicholas Avenue, Baltimore, MD 24 hours a (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature 31. Date filed (Month, Day, Yea

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Jack Titus MD.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year) December 18, 2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 9:13 PM December nae 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltsmore Universit of Maryland Medical Cent N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months 6/2/2011 Director 215-91-1287 show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland ms 23a or 28a-f sho must be notified at Director Baltimore 1 🌠 Yes 2 □ No MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a 21217 Apt. 511 501 Dolphin Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after Black 1 Yes 2 No Specify. If Yes Give "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 1/2 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1/2 His Me Elementary/Seconday (0-12) College (1-4 or 5+) N/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angela Scott Antoine T. Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21217 Angela Scott-Mother 501 Dolphin St. Important: If item any injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) 12/23/2011 Lansdown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North MD 21202 Baltimore, Ave. 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2: stress ndrone ·esour disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Dise to for as a pursequence of cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death detached 9 Unknown 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 No After this certificate Yes 2 □ No 25. Was case referred to medical examiner? Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending death. Accident Investigation 24 hours after deat Funeral Director; filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune
completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of m D0050845 address of person who completed cause of death (Item 23a) (Type, Print) S. Grune St BIKMOR MD 21201 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

2

			Р	lease	Type or Pri								egible.	
		1	For State Registrar		State of M	aryian		rtificate				Reg. No. 2	011	41118
	Physicia	n/	1. Decedent's Name (First, M Norman C. S	iddle, Lasi Streik	,						2. Date of Dea Month December	Day	2011	3. Time of Death 8:30 PM
1	Medic Examin		4a. Facility Name (if not instit					4b. City, To	own, or Lo	cation of Death	Decano		unty of Death	10.30 1
1	ZAGIIIII	Ŭ.	424 Lorraine	Avenu	ıe			Ess	sex			B	altimo	re
	Funeral Director		5. Social Security Number	6. Se	x 7. Ag		ast birthday) 77 Yrs.	If Under 1 Months		Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da 01/05/	th y, Year)	9. Birth Cour Mary	place (State or Foreign
			218–30–7399 Usual Residence of Deceder								101/03/	1334		
	yland -f sho ed at	ctor	10a. State 10b. Co	_{unty} timor		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits 1 ☐ Yes 2 🛣No
	or 28a	Director	10e. Street and Number	CIROL	.e -	255	<u></u>	10f. Zip (Code			10g. Citizer	of What Cou	
	with t	Funeral	424 Lorraine	Avenu	ie			21	1221			U.S	.A.	
	death item:	Fun	11. Marital Status		12. Was Decedent Armed Forces?		3. 13.	Was Decede If Yes, specif	nt of Hispa y Cuban, N	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
036	within 72 hours after death with the Manyland glein than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🗵 3 ☐ Widowed 4 ☐ Dive		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	No		1 ☐ Yes 2	XNo S	Specify:		Spe	ecify: Wh	ite
21215-0036	2 hour "natu edical	Completed		cedent's Ed highest gra	lucation de completed)		(Give	edent's Usual kind of work	done durir	n ng most of work	ing	16b. Kind	of Business In	dustry
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Maryland	and and is n		19a. Informant's Name/Rela Geraldine St		pe, Print) (Wife)					Number or Rura venue,				
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altin	nit. Pa artme ortani injury		4 Donation 5 Ot 21. Signature of Fuperal Ser			вау		remato 2. Name and			2/2011			Maryland
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s, P.O.	requires that the der been signed by the s should be detached	d by Pr	Part II. Other significant co	nditions co	ontributing to death	but not res	sulting in the	underlying ca	ause given	in Part I.				the cause of death?
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al B	an: The tifficat tor, pa	Be C	25. Was case referred to me	dical					26. Place	of Death (Chec		2 NO	I L Tes	2 110
Vit.	nysici nis cer I direc	은	examiner? 1 Yes 2 No					ent 3 🗆 DO	Other:	4 Nursing H	ome 5 Resi	dence 6	Other (Specia	5y)
on of	nding Pt ath. r: After th e funeral	icate:		ending ovestigation	28a. Date of inj (Month, D	ury a <i>y, Year)</i>	28b. Time o injury	of 28	sc. Injury at work? 1 \(\sum Ye	s 2 🗆 No	28d. Describe	how injury o	ccurred	
)ivisi	il or Atte after des Director	Certif		Could not be etermined	28e. Place of In building, e	jury - At he tc. <i>(Specif</i>	ome, farm, st	treet, factory,	office		28f. Location (City or To		lumber or Rura	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical Certificate:	(Check 2 Med	ical Exami	sician: To the best oner: On the basis of se Practioner: To the	examinatio	n and/or inve	estigation, in m	ny opinion,	death occurred a	at the time, date	and place, ar	nd due to the c	ause(s) and manner stated.
	To the vithir comp	2	29b. Signature and title of c	ertifier (29c.	License nu	umber			signed (Month	Day, Year)
					nem·D.					57465			12/2	
	6		30. Name and address of pe		St MID.	2835	Smi	mm	520	3 Bal	timore	MD	2170	9
	Sta Registr		31. Date filed (Month, Day, Y		32. Regist	rar's Signa	far	Ken						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 19, 2011 12:42 P M Stephen Smallow, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Arnold 936 Burnett Avenue Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 217-46-2912 Director 1 🗶 M 2 🗆 F Yrs. Maryland Jan 11, 1950 61 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10b. County aţ 10a. State Director the Medical Examiner must be notified 1 Yes 2 X No Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 23a Funeral 21012 United States 936 Burnett Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force "natural", or þ 1 X Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Divorced Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Brick Mason 12 marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H မ Sophia Bobenko Stephen Smallow, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Legartment of Health an Important If item 27 is n any injury or other tone. 2127 Millhaven Dr. Edgewater, MD 21037 Theodore Smallow / Brother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Woodbine, Maryland Final Journey Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death One Jean Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the burial-trar and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year ğ Day Pregnant at time of death 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ myelodysplastic 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown sy navoure Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No Hospital or Attending Physician: The B 24 hours after death. Funeral Director: After this certificate h 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident injury work 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature an 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) Name and address of Stuart Medical Pavkway, Annapolis, Md. 2003 Selonick. MO 31. Date filed (Month, Day, Registrar's Signature State Registrar

11-09422 Jose Sweeney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ose Sweeney		St 1- For State	ate of Maryla		artment of		and	Menta	l Hy			20		4112
Physicia		Registrar 1. Decedent's Name (First, Midd	e,Last)						2	. Date of Dea			3. Time	of Death
Medical Exami		Jose					Month Decembe		Day 15, 2011 1140 hrs 4c. County of Death					
		4a. Facility Name (if not institution University Hospital	n, give street and ກເ	umber)	4	lb. City, Tow Baltimoi		ocation of I	Death		4c. (County of D	eath	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1	_	If Under 2		8. Date of B	irth(MM/DI	D/YYYY) 9.	Birthplace (State or
Director		579-17-0089	1XM 2F	22	Yrs.		Days	Hours	Min.	08/12,	/1989	FC	Count Was	shington DC
		Usual Residence of Decedent		Lia, all	Ŧ								10d lo	side City Limits
w any		10a. State 10b. County		Toe. City,	Town or Locati	_								Yes 2 No
Maryland 28a-f sho i at once.	ğ	MD			Laur						40- 0:11			100 2110
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once	Director	10e. Street and Number	•	10f. Zip Code					10g. Citizen of W					
ith the		9687 Muirkirk F	cedent Ever in U	C 42 Wo		708		igin? (Specify Yes or No- 14. Race - American Indian, Black,					an Black	
ath w	Funeral	11. Marital Status 1 Never Married 2 M		orces?	If Y	es, specify C	uban, M	Mexican, P	uerto R	ican, etc.)		White, et		ari, Didok,
ter de		3 Widowed 4 Div	2 X No ar	1	Yes 2	No	specify:			s	pecify: B	lack		
tural	d by	15. Decedent's Education (Spe		16a. Deceden	t's Usual Occ	cupation	n (Give kir			16b. Kir	nd of Busine	ss/Industry	_	
5-0036 led within 72 hours at tygiene. other than "natural the Medical Examin	ete	Elementary/Secondary (0-12)	during me	ost of workin	g life. L	DO NOT us	se retire	a)						
21215-0036 Montal Hygiene. marked other than	Completed	11th	Ca	rpente						rivat	.e			
5-0 iled v Hygi		17. Father's Name (First, Middle,					,		bt, Middle, Maiden Surname) Dunn Route Number, City or Town, State, Zip Code) Laurel, Maryland 20708					
2121 Id be fil Mental I	Be	Jose David Sv 19a, Informant's Name/Relations	10h Mailine	Address /					toute Number, City or Town, State, Zip Code)					
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e, MD 21215-0036 1 and 2 should be filed within 72 Health and Mental Hygiene. item 27 is marked other than " r traumatic event, the Medical	H	20a. Method of Disposition	(POCICE)	20b.	Place of Dispos	ition (Name				Date			y or Town, S	
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Baltimore, permit. Pages lar Department of Hee important: If ite		4 Donation 5 Other Sp 21. Sc ature of Funeral Service	surrect									rand		
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex		Word nits	00000000		45	94 Bee	ech	Road	ree Te	man Fi	unera Hills	ı ser	vices 20748	3
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Box 68760, e death certificate but attending physical for use as the but		IF FEMALE: 23b. Was decedent pregnant in th		outcome of preg birth		tal death	3	Ectopic p	regnan	Cy		Date of del Month	Day	Year
x 68 h cert tendin use a	S	past 12 months?	4 Preg	nant at time of de		her (Specify,								
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n of ding Pl	등	27. Manner of Death 1 Natural 5 Pen	Oct 16	e of Injury h, Day,Year) , 2011	28b. Time of le 1815 hrs		_	at Work? es 2 ✔ N	, Is	ubject pa	ssenger	r of vehic	lę involve	d in motor
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical		miner: On the basis	of examination a										(s)
To wit To con	Mec	29b. Signature and title of certific	and manner	stated.		29c. L	icense	number			29d. D	29d. Date signed (Month, Day, Year)		
O 44		1/1 111	11: 1	TI	>	0	D.C.M	I.E.		4	Dece	ember 16	, 2011	
7 cm		30. Name and address of person	who completed cau	use of death (Iten	с. Д ,				_		.1			
V 0		Theodore M. King, Jr.	_	ant Medical I		900 W. B	altimo	ore Stre	et, Ba	ltimore, M	ID 2122	3		
	tate	31. Date filed (Month, Day, Year)	0044 0	Registrar's Signat	ug Z	Red								
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BLETOR				State of Maryla	-	rtment of F		d Mental Hy	201	1 41121
78				Registrar 1. Decedent's Name (First, Middle, Last)		incare or E	Journ	2. Date of De		3. Time of Death
3		Physicia Medic		Judith Lynn Singleton				December 1	oer 17, 20	11 1:41 P. M
2	CH T	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or		ath	4c. County of D	
3		F		Upper Chesapeake Medical Cen 5. Social Security Number 6. Sex 7. Age (In yr	ter	Bel Ai		rs. 8. Date of Bir	Harfo:	rd. Birthplace (State or Foreign
3		Funeral Director		212-56-7410 1□M2\\$F 6	Vro	Months Days	Hours Mi	in. (Month, Da		Country) Maryland
3	ъ	t tow	_	Usual Residence of Decedent	City, Town or Loc	ation		rep.	11, 1559	10d. Inside City Limits
-	with the Maryland	a-f sh ified a	Funeral Director		Edgewood					1 ☐ Yes 2 🔀 No
JUSTIH	the M	or 28 se not	l Dir	10e. Street and Number	Lagewood	10f. Zip Code			10g. Citizen of What	Country?
20	h with	nust b	nera	604 Hartwood Lane		21040			USA	
	r death	or iten niner r		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 5⁄2 No		as Decedent of H Yes, specify Cuba		(Specify Yes or No- erto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
	JU36 urs after	ıral", c Exan	ed by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 🔀 No	Specify:		Specify:	White
	ا -دا 2 hou	"natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occup ind of work done o	during most of w	vorking	16b. Kind of Busine	ss/Industry
1	21215-0036 within 72 hours after	ene. r than the M	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)) NOT use retired) I emaker			Own Hom	e
3	iled v	l othe vent,	Be	17. Father's Name (First, Middle, Last)					, Maiden Surname)	
~	ya IId be	it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	입	Joseph Conrad Barron Sr.			Julie	(unk) L	epka	
7	Mar 2 shou	th and 27 is n traum		19a. Informant's Name/Relationship (Type, Print) Judy Bellmyer / Daughter					er, City or Town, State, aryland 21	
17.	ore,	f Heal item other		20a. Method of Disposition 20	b. Place of Dispos	sition (Name of		Date Date	20c. Location - City	
	Ino Page	ant; If		1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		atory or other place Service C		2/22/2011	Towson,	Maryland
-	Saltır vermit. Pa	Department of Health as Important; If item 27 is any injury or other trauonce.		21. Signature of Funeral Service Licensee		Name and Addre			Funeral Ho	
i				23a. Part 1. Enter the disease, or complications that caused the d						yland 21009 Approximate
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- (68/60 certificate be	ding parage as	n/Me	IF FEMALE: 23c. If yes, outcome of pre 23b. Was decedent pregnant	gnancy				23d. Date of	delivery
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	that the	d by the	Phy	g Unknown Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause gi	ven in Part I.	23e Did	tobacco use contribut	e to the cause of death?
		signed d be d	Completed by	LOPS	roodiling in the d	nderlying bades g.				Probably 4 Unknown
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	Of VItal Records, ig Physician: The law requires	ate has page 2	mo		, -			perf	formed? deat	h? Yes 2 No
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3.7	of Vital Physician:	rthis o eral dir	2	27. Manner of Death 28a. Date of injury	2 ER/Outpatien 28b. Time of	t 3 DOA Oth	4 L Nursin		idence 6 Other (S)	pecify)
	ISION C	ath. : After ie fune	icate	1 Natural 5 Pending (Month, Day, Year 2 Accident Investigation	r) injury	wor	k?] Yes 2 □ No			
	DIVISION tal or Attendir	ter de irecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe		et, factory, office			(Street and Number or wn, State)	Rural Route Number,
Ċ	Hospital	ours al eral D filled i		29a. Certifier 1 Certifying Physician: To the best of my kr	nowledge, death o	occurred at the tim	e. date and place	ce, and due to the	cause(s) and manner a	s stated.
	the Hos	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the best	ation and/or invest	igation, in my opini	on, death occurr	red at the time, date	and place, and due to t	the cause(s) and manner stated.
	To t	Nith For	_	29b. Signature and tille of certifier		29c. Licens			29d. Date signed (M	
				30. Name and address of person who completed cause of death (Item 23a) (Type P	rint)	3420		December	
6				Sid 2. Kharal , 500 U	pper ch	resapeak	e Dr 1	3el Air	MD 210	14
	IF	Sta Registra		31. Date filed (Month, Day, Year) 32. legistrar's Si	gnature	ares				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Karen C. Sylvester 2011 18, December 9:30 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford <u>Upper Chesapeake Medical Center</u> Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Year 1944 1 M 2 XF Feb. 21 Kentucky **Director** 181-40-7227 66 Usual Residence of Decedent or 28a-f show notified at 10a. State 10h County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 Yes 2 No Harford Abingdon Maryland 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? must be 23a 21009 USA 1204 Abinjud Drive iral", or items 2 Examiner mus 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hours Department of health and Mental Hygiene. Important if item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Own Hame Homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Florence (unk) Ramey Joseph (unk) Clevinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1204 Abinjud Drive, Abingdon, Maryland 21009 Chester R. Sylvester / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify) 12/23/2011 Timonium, Maryland Dulaney Valley Mem. 21. Sig ar re of Funeral McComas Funeral Home, P.A. 22. Name and Address of Facility 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final nset and Death Ph, sician/ evere disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Unidenying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tailure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 N 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 6 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 2 ☐ Accident 3 ☐ Suicide M 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a

To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practic ner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one districtline, date and place, and due to the cause(s) and mainler as state 29b. Signature and title 29d. Date signed (Month, Day, Year) D0053568 December 19, 2011 upper Chesapeake Drive 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date BelAir Mary land 21014 hoh >50 N State Registrar DHMH 17 Rev 7/2009

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 23a, State of Maryland 2 Department of Death and Mental Hygiene Registrar Reg. No. 2. Date of Death 11/03/2011 1. Decedent's Name (First, Middle, Last) 3. Time of Death Charles K. Slifer Physician/ Month 135 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death zen Cape + Rehabilitation Ctp. 1900 Bosens Frederick mi -Rederick Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 🗷 M 2 🗆 F Director 217-32-7358 73 08/20/1938 Maryland or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Completed by Funeral 1900 Rosemont Avenue 21702 U.S.A. or items death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 X Yes 2 No 1 Never Married 2 Married 72 hours after X Yes 3 Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Specify. "natural", 3 X Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction 8 Carpenter marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Virginia Rider Anna George Franklin Slifer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a D Street, Brunswick, MD 21716 Deborah Parsons / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Findoutant: If ite ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🕅 Donation 5 🗌 Other (Specify) 11/08/2011 | Hanover, Maryland Anatomy Gifts Registry 21. Signature Funeral Service Li pinsee any in 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause of ach line. Cancer of the Lung Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran CERTIFICATION Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the E FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Dav Year Month Pregnant at time of death be detached the Unknown been signed by Part I_ Other significant conditions contributing to reath but no esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Conknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 2 110 1 Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 1 X Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 NO Investigation Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) ne and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 18 2011 Physician/ SALINS 1:40 P^{M} JOSEPH EDWARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WESTMINSTER CARROLL DOVE HOUSE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Birthpia-Country) NJ **Funeral** 1 🛛 M 2 🗆 F Hours 09/24/1929 82 Yrs **Director** 579-26-9811 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 28a-f 1 Yes 2 X No SYKESVILLE MD HOWARD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 875 WINDRIVER DRIVE 21784 USA items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Armed Forces Black, White, etc. ö ğ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates er than "natural", the Medical Exa Completed 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) DENTIST **DENTISTRY** ed other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 127 is marked or traumatic ever ပ KATZ SOLOMON SALINS BERTHA and ∖ is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 875 WINDRIVER DRIVE, SYKESVILLE, MD 21784 Department of Health Important: If item 27 any injury or other the RITA SALINS 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/20/11 OLNEY. MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Servi MD 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a Part 1 Enter the disease Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death each line Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence bij. the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent preg*n*ant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has I performed 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 2 1 🔲 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 🗹 Natural 5 Pending work? 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature & d title of certifie 29d, Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Name and address

31. Date filed (Month

who completed cause of death (Item

32

20

State Registrar 29b. Signature and title of certifier

Anne Laws, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, Ste 4105 Bellemare,

29c. License number

29d. Date signed (Month. Day, Year)

DHMH 17 Rev 06-2011

MD

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Chen

DHMH 16 Rev 6/95

Registrar

Alexander

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Michael John Schertle, Sr. 6,2011 Medical December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2234 Thomas Run Road Bel Air Harford If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 212-34-1113 **Director** 1 X M 2 - F July 10,1937 Maryland 74 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No Harford Bel Air Md. 10e. Street and Number ò 10g. Citizen of What Country? must be 23a Funeral 21015 USA 2234 Thomas Run Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces Black, White, etc. 5 à 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 X Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 11th Forest Products Long Shoreman Be 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN 17. Father's Name (First, Middle, Last) UNKNOWN ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Department of Health Important: If item 27 any injury or other to DTR. 1308 Willow Chase Drive Diana M. Schertle Bel Air, Md. 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Atlantic Crematory ☐ Burial 2 K Cremation 3 ☐ Removal from State 12-10-2011 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Schimunek FuneralHome, Inc. 610 W. MacPhail Road Be1 23a. Par 1. Enter the di ea e, or comp ca s ock, or heart failu e List only one d ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Diss to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown g Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home XXX Residence 1 Yes 2 No Hospital ျ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death 1 Natural 28b. Time of Certificate: 28c. Injury at Hospital or Attending 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) within To the 29b. Signature and title of 29d. Date signed (Month, Day, Year) 70065827 address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 20 DONALD JAMES SIEWERT 9:35P M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County 904 Wellington Road Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) Director 396-34-0353 1 X M 2 🗆 F 72 Nov 25, 1939 Wisconsin show 10d. Inside City Limits 10b. County 10c. City, Town or Location at Completed by Funeral Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 🗌 Yes 2 💢 No Maryland Baltimore County Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural", or items 23a lury or other traumatic event, the Medical Examiner must b 904 Wellington Road 21212 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2 💢 No 1 ☐ Yes 2 X No Specify White Specify. 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) New York County Elementary/Secondary (0-12) College (1-4 or 5+) Deputy District Attorney Office Attorney Bureau Chief Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hans Erik Siewert Anna Mangan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 904 Wellington Road, Baltimore, Maryland 21212 Margaret S. Siewert (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory 12/22/2011 | Baltimore, Maryland 21. Signatu/eci-Fundis Service Lawson MATCHELL WIEDEFELD FUNERAL HOME INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ oaus disease or condition Medical resulting in death) Due to (or as **Examiner** Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Yes 2 No 9 Unknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 16Ca.SP 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 N 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XNatural injury work? 5 Pending after death. 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

419 Redwood St. Suite

University Medical Center, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Leslie Robinson, M.D.,

Les 1...
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ I7. 2011 6:18 December Sevim Sanver Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice - Casey House Rockville Montgomery 7. Age (In vrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) Country Director 524--54-9505 1 🗆 M 2 💢 F 80 January 30,1931 Turkey Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 Tyes 2 X No Maryland Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 11613 Greenlane Drive United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uld be file Mental P ည Zekiye Yasar Osman Salman should by and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Ayda Sanver / Daughter 11800 Rosalinda Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 20. cemetery, crematory or other place)

Montgomery
Crematorium Inc. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Actions of Facility Funeral Home/Bethesda-Chevy Chase, Inc. Hand fan M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Complications of C. Difficile disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Seizure Disorder Sequentially list conditions, if any leading to immedicause. Enter Underlying Exami Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 2 X No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 X No Jas prior to completion of cause of page death? this certificate 2 No 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 💢 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) House 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural injury 5 Pendina s after death.

I Director: Af
ed in by the fu 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in 24 hours Medical 1 🗮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D0060634 December 18, 2011 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland 20855 Bindu Joseph, M.D. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Moder of the contract of the c 12: 40 R. Charles Keith Trautwein Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death **Examiner** Rossville Franklin Square Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days 1 😿 M 2 🗆 F **Director** 212-26-5903 Usual Residence of Dec December 30, 1929 Maryland 81 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No Perry Hall Maryland Maryland Baltimore ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 17 High Button Court 21236 USA 12. Was Decedent Ever in U.S. Armed Forces?

1XX Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify White Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Baltimore City Police Officer traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Carter 17. Father's Name (First, Middle, Last) William Trautwein permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17 High Button Court, Baltimore, Maryland 21236 Evelyn E. Trautwein Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burjal 2 Cremation 3 Removal from State Lorraine Park Cemetery 12/20/2011 Donation 5 Other (Specify) Woodlawn, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Burgee Henss-Seitz Funeral 3631 Falls Road, Baltimore, Funeral Home, 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final DIGHETES Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) CHRONIC Examiner myocarone Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown PLEGSA Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 DECONSR 2 No 1 Yes Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) funeral (28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death. Accident the f Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) BROWN 31. Date filed (Month, Day, Year) State 2 2011 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Manuard / Department of Health and Mental Hygiene state of Manuard / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Lawrence Thrash, 16:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital N/A Baltimore 5. Social Security Numbe **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month. Day, Year) Director 259-92-2690 1 ¥M 2 □ F Usual Residence of Decedent Dec. 1, 1955 Georgia or 28a-f show notified at the Maryland 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number ö 10f. Zip Code er than "natural", or items 23a of the Medical Examiner must be 10g. Citizen of What Country Funeral 228 S. Mason Ct. 21231 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4X Divorced Specify: Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William L. Thrash, Jr. Jean Wright'i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danielle Thrash/Daughter 228 S. Mason Court Baltimore, MD 21231 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 4 Donation 5 Other (Specify) Greenmount Cemetery 11-25-2011 Baltimore, MD 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final MUH Ph sician/ Inset and Death disease or condition resulting in death) MAPIO Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine cardiac allest Cause (Disease or injury activity that initiated events resulting in death) Last ician ar burial-t Due to (or as a consequence of MEDICAL EXAMINE Physician/Medical P.O. Box 68760 the as IF FEMALE CERTIFICA 23b. Was decedent pregnant yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? the Hospital or Attending Physician; The law 24a. Was an autopsy performe 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my manner stated. (Check only one 29d. Date signed (Month, Day, Year) AT 24 38946 11/18 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) onation 29 S. Paca Street Baltimere MD 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician /Medical 01:10 AM 2011 DECEMBER 20 DONALD 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) //-22-/93 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Sex 1 M 2 □ F **Funeral** Days 214-28 518 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show aţ 1 Yes 2 □ No Director notified ms BaltIMORE undalk 10g. Citizen of What Country? 10e, Street and Number 6 Examiner must be Items 23a USA 21222 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: White ģ 3 Widowed 4 Divorced KOTEA "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OPTICAL 12 ju IAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth ROBERS 10WNS ၉ EIMER 19b. Mailing Address (Street and Number or Rural Route Imber, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DUNGAIK, MD 21822 Hdmira 10WNS Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Tremation 3 Removal from State 1/2011 Baltimore 4 Donation 5 Other (Specify) CW Crematory 1/2
22. Name and Address of Facility - ASKON FUNERAL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. W,110W Approximate Interval Between Onset and Death Immediate Cause (Final 4 DAYS **Physician** SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 4 DAYS PNEUMONIA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events as the conditions of the conditions o Due to for as a consequence of as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 No Yes P.O. I the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 of Vital Records, 2 No 3 Probably 4 XUnknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death Check onl one director, 25. Was case referred to medical Be examiner? Hospital: 1 X Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation Hospital or Attending 1 X Natural Injury 1 🗌 Yes 2 🗆 No death. To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 DECEMBER 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 KARUNAKAR 31. Date filed (Monte, Day, Year) State Registrar

DHMH 17 Rev 1/2001

	For State Registrar	State of N	.ar ylal			te of D				eg. No.	201	411		
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	10a. State 10b. County		10c. Ci	ty, Town or Loc	cation									
	Maryland Mon			01r	ney					1 🗆 Yes 2 🔀				
alD	10e. Street and Number		10f. Z	ip Code				0						
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	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1	☐ Yes	2 🛣 No	Specify:			Spe	Montgomery 9. Birthplace (State or Forei Country) 9. Birthplace (State or Forei Country) 9. China 10d. Inside City Limi 1			
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ادہ	12 17. Father's Name (First, Middle, Las			Ca	retak		Nama /Fi			3. Time of Death 2:10 P County of Death Montgomery 9. Birthplace (State or Foreig Country) 939 China 10d. Inside City Limits 1 Yes 2 N Itizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: Asian Kind of Business/Industry In El Congregation Surname) ieu Town, State, Zip Code) 1 and 20832 Cocation - City or Town, State Interval Between Onset and Death 16 Years 1 Year 23d. Date of delivery Month Day Year Use contribute to the cause of death? 1 Year 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year Country Countr				
	Truc				16. Mother's	,								
	19a. Informant's Name/Relationship	19b. Mailin	a Addres	ss (Street a	nd Number or					o Code)				
	19a. Informant's Name/Relationship (Type, Print) San B. Thanhly / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City of 3607 Bermuda Court, Olney, Mary													
	20a. Method of Disposition			Place of Dispo cemetery, cren	sition (Na	ame of	De	cellib	er 21,	20c. Locat	ion - City or	Town, State		
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	21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Funeral Home/Bethesda-Chevy Chase Inc													
Ц	1 June Jil		M01	360 75	57 Wi	sconsi	n Avenue	e. Bet	hesda,	Maryla	nd 2081	[4–3501		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Interval Between		
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		Due to (or a			Syndrome						1 Vanz			
<u> </u>	Sequentially list conditions, if any, leading to immediate	.c 53	maron	ne					1 Ital					
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events													
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ly S	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)										Asian Gind of Business/Industry the El Congregation Surname) ieu Town, State, Zip Code) land 20832 cocation - City or Town, State nesda, Maryland esda-Chevy Chase Inc. yland 20814-3501 Approximate Interval Between Onset and Death 16 Years 1 Year 23d. Date of delivery Month Day Year use contribute to the cause of death? IX No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) ry occurred			
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сеппсате:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of in (Month, D		28b. Time of injury		28c. Injury work			. Describe ho	ow injury oc	curred			
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Med	/ N . / /									-		00 0011		
Med	1					D.	<u> 29675 </u>			Dece	mber	20, 2011		
Med	30. Name and address of person where Ralph V. Bocci													

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 5:43 P M December Xao Q. Vien Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 🛛 F Months Davs Hours Min Augus t 23, Country) China 241-31-5655 95 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County within 72 hours after death with the Maryland or 28a-f sho notified at 10a. State 10c, City, Town or Location Director 1 Yes 2 X No Potomac Maryland Montgomery 10f. Zip Code 10e, Street and Number 10a. Citizen of What Country? ō be ms 23a Funeral 20854 5 Candlelight Court United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iten ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Asian 3 X Widowed 4 Divorced Completed Il Hygiene. other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker n and Mental Hygien 7 is marked other the raumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. Not Available Not Available 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candlelight Court, Potomac, Maryland 20854 Ha Chen / Daughter Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of December 23 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) Gate Of Heaven Cemetery 2011 Robert A. Pumphrey Funeral Home, Rockville, Ir 300 West Montgomery Avenue, Rockville, Maryland 20850 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury Urinary Tract Infection that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hypernatremia Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for Month 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aspiration Pneumonitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA ျ this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: s after death.

I Director: After the in by the funeral 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural injury 5 \square Pending work? 2 🗆 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical E'Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3

3

State Registrar 29b. Signature and title of certifie

Sudarshan Siva,

5,50pm

JUDARSHAN

30. Name are address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29c. License number

065312

8600 Old Georgetown Road, Bethesda, Maryland 20814

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G923 1/03/2011 Jh State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 18, 2011 10:30 A M Margaret E. Voigt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 5. Social Security Nember 7. Age (In yrs. last birthday) Days 213-24-3839 Director 1 M 2 X F 83 April 7, 1928 Washington, D.C. show or 28a-f shove on outsided at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Washington Grove 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 300 Ridge Road 20880 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Specify: White 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) realth and Mental Hygiene." m 27 is marked other than " Federal Government Elementary/Secondary (0-12) College (1-4 or 5+) 12 Financial Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rudolph Rafael More Hester Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Sherry L. Dionne/Daughter 516 Beall Avenue, Rockville, Maryland 20850 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place December 22, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Inc 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 Pumphrey Funeral Home/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, M01498 Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Pancytopenia- Severe Thrombocytopenia Medical Due to (or as a consequence of): Examiner Chemotherapy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): executed Cause (Disease or injury that initiated events Anal Cancer 030 Due to (or as a consequence of): resulting in death) Last /Medical the Hospital or Attending Physician: The law requires that the death certificate be Neutropenic Fever IE FEMALE: jan/ 23c. If ves. outcome of If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 4 Pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DNR Status 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛛 No 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending s after death.

I Director: Aft 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide determined era. Joy filled ir To the Hospital within 24 hours a To the Funeral C ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a le of certifie 29d. Date signed (Month, Day, Year) D0055148 December 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Delroy Peter Anglin, MD 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year)

DEC 2 2 2011 32. Registra s Signat State Registrar

Baltimore, Maryland 21215-0036

Box (

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 12/20/2011Physician/ 7:30 P M Mildred L. Withrow Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Lorien Nursing Home Taneytown Carroll Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min **Director** 220-34-0028 1 M 2X F 95 11/19/1916 WV Usual Residence of Deced or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2X No MD Carroll Westminster be filed within (2 1100).
Interd other than "natural", or items 23a or 28.
Ince event, the Medical Examiner must be no 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 117 Dunrovin Ave. 21158 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ANO Specify. Specify: White Completed 3XXWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Springfield Hospital Nurses Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be file of Health and Mental I If item 27 is marked o ပ McKinley Sarver Willie Grace Bostic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Rippeon/Daughter 4 Sylvia Circle, Thurmont, MD 21788 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If ite any injury or of cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 12/23/2011 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery Mt. Airy, MD 21. Signat re of Funeral Service Licenses ²²Burrier Que en Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Enter the disease, or complications that caused the death. Do not enter the mode of dy or heart failure. List only one cause on each line. Cause (Final Onset and Death Physician/ or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed -trar Due to (or as a consequence of): g physician ar resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Day Year 4 Pregnant at time of death 9 Unknown g Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Kidney Disease Vibrilation Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one Hospita Other 2 **1** No 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral I

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) #0061206 d. Poole Rd. Westminster 31. Date filed (Month, Day, Yaar)
DEC 2 2 2011 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Physician/ 3:50 SON 2011 5PORGE WRIGHT December Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORECIT BALTIMORE HARBOR HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours Min March 25, Virginia 1 M M 2 □ F Director Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10a. State with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Anne imore Hrunde 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral "natural", or items 23a 21225 Avenue oris 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Was December 2 Armed Forces? 1 ★ Yes 2 □ No If Yes, Give +-12-51 Year or Dates. +-12-53 Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify. 3altimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72.1 th and Mental Hygiene. '7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ည alvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Baltimore 2123 Doris Ave Idredh 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 12-16-11 emeten Lawn ☐ onation 5 ☐ Other (Specify) 22. Name and Address The ility SLACK FUNGRAL HOME of Fyral Service Lio MO 21043 PIKE ElliCOU City Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final isease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it are sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Natural 5 Pending 2 Accident Investigation 24 hours after deat Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29c. License number 29b. Signature and title of certifier 11 ecember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANOVER

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) ^D20. Physician/ 2011 11:48 A M December Stefan W. Wurzer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Director 387-44-3962 1 **X** M 2 □ F Austria Dec 26, 1926 84 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10a. State event, the Medical Examiner must be notified at Director 28a-f 1 Yes 2 XNo Temple Terrace Florida Hillsborough 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 23a Funeral United States 33617 1326 N. Riverhills Drive items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Beer Company 4 Brewmaster Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Anna Holzeisen Stefan Wurzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s
of Health
item 27
other tra 8704 Liberty Lane Potomac, MD 20854 Jolanda Mathrani / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/22/2011 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Coing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Ph_sician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Ischemic Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and s the burial-transit Cause (Disease or injury that initiated events Atrial Fibrillation Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimer's Disease, Dementia, Hypertension 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b lirector, page 2 s autopsy performed? Yes 2 K No Hospital or Attending Physician: the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 2 XNo 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation after death 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral C Medical The detifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. tifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 29b December 21, 2011 H57270 completed cause of death (Item 23a) (Type, Print) John Lynch 8600 Old Georgetown Rd. Bethesda, MD 20814 31. Date filed (Month, Day, Year) **DEC 2 2 2011** State

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,27,28a-f per me. 992,12/16/2011dhb

Beg. No. For State Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Williams, Sr 5:16A M Richard Jovember 20 1 Medical not institution, give street and mmber, or Location of Death 4c. County of Death **Examiner** timore harraway Koa 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Hours 1 ■ M 2 □ F **Director** 72 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 10b. County Director timore 1 ¥Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Number 23a Funeral KSH rarrawa items (13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ö þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than DO NOT College (1-4 or 5+) other traumatic event, the Be မ ee 19b. Mailing Add ess (Street and Number Department of Health an Important: If item 27 is 1 tsmore, MD 21227 Williams 6361 Burnette 20a. Method of Disposition Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State ematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) ure of Fundral Service License 21. Sian 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ subdural Hemorrhoge disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence bi) If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 No ed by the a of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has autopsy performed? 1 🗌 Yes 2 🗎 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending Division **Unknown**M 1 ☐ Yes 2 XNo Subject fell Unknown 2 X Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 900 S. Caton Ave. filled in by 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office determined Hospital Baltimore, MD within 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 MSRajapane M.D D0057465 11/23/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Smith AV SZU3

2835

✓ 32. Registrar's Signature

ROJAPAKH, MID

1 6 2011

31. Date filed (Month, Day, Year,

21209

Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Physician/ 12:14PM TRELL WILLIAMS 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) **Director** 1 **X** M 2 □ F 59Yrs MD 06-06-1952 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral HAWKS BURY ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK Completed 3 🗌 Widowed 4 🗆 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) TANITORIAL LABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DSCAR JAMES WILLIAMS ELIZABETH JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SISTER HAWKSBURY RD. BALTO, MO. 21208 item 27 20b. Place of Disposition (Name of Date BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN GREENE FUNDEAU SEVS 21. Signatury of Fundal Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Conce montas disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the at Id be detached for 1 Yes 2 9 Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 ANO 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) No Spice 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Matural Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation To the Funeral Director: A completely filled in by the t 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier December 19 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARREN M 6701 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 1:10 P M Ola Gaye Wampler December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Edgewood 2211 Snow Road If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 M 2 XF May 9, 1926 Days Hours Virginia 85 Director 217-24-7193 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f sho filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 XNo Edgewood Maryland | Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21040 2211 Snow Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian. 11 Marital Status Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Tes 2 No White Completed 3 Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me. Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Factory Seamstress 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ada (unk) Tiller Cummings Robert Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 Snow Road, Edgewood, Maryland 21040 Judy Blackburn / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from Abingdon, Maryland Cokesbury UMC Cem. 12-23-2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. of Funeral Se Sign 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (d Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗷 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🛮 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier соmpleted 29b. Signature and title of cdr 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of pe

filed (Month, Day,

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e of death (Item 23a) (Twoe, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manuard / Department of Health and Mental Hygiene Registrar

State of Manuard / Department of Health and Mental Hygiene Certificate of Dooth 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MATTHEW Physician/ J. WUE Month M9 FG:80 MUENBER ,2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death UNIVERTITY OF MOVED WHID MEDICAL CONTER BOLTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) 1 M M 2 □ F **Director** 535-11-9396 27 Yrs. South Carolina FEBRUARY 17, 1984 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified Spotsylvania Spotsylvania Virginia 28a-f 1 ☐ Yes 2 🔯 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 5913 West Copper Mountain Dr. 22553 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu ence. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Student Law School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Michael S. Wise Mary Susan Vandenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael S. Wise - Father 5913 West Copper Mountain Dr. Spotsylvania, VA 22553 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Saints Cyrii and Methodius Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/7/2011 Woodford, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Covenant Funeral Service 4801 Jefferson Davis Hwy. Fredericksburg, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACULT KESPIRATORY OLITICEST SYLIDVAME Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PHEUMONIA JERGIL Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami death certificate be executed g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICAT Physician/Medical Division of Vital Records, P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant
Unknown Pregnant at time of death Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by KNUTH YOMEY THOUGH 1 Yes 2 No 3 Probably 4 Unknown GATTROITMENTINGE BLEEDING 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? this certificate has performed? Yes 2 No 2 No 1 Yes Hospital or Attending Physician: T 24 hours after death. Funeral Director: After this certifica completely filled in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 110 Other: ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year, RIGAGIA NOVERABOR 30, 2011 and and the 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 JOUTH CHEENE JINGET cryl BOUTINGLE CHANKINAM. TOUM 31. Date filed (Month, Day, Year 32. Registrar's Signature

DHMH 17 Rev 06-2011

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John wade Physician/ 1115A M Delember 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3510 Abbie Place Windsor Mill 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Country) **Director** 249-24-8579 1X M 2 D F 97 11-14-14 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Windsor Mill 1 X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 3510 Abbie Place USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. African 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: If Yes, Give Specify: American 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) Construction Laborer 3rd. Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Luella James Wade Bynum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2124419a. Informant's Name/Relationship (Type, Print) Mary Wardlaw-Daughter Health a 3510 Abbie Place Windsor Mill, Maryland permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 12-22-11 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. Street Baltimore, MD 21217 638 N. Gilmor Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure sist only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Struck Renal Disease Onset and Death Ph_sician/ ENd Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underphys Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): use as the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has page 2 autopsy prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☑ No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) thin 24 hours a Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifjer Wilgipalmen-D 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5703 N. S Rajapakk, Mil. 2805 Smith N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **DEC 22** Registrar

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			Registrar	-41	Ce	rtificate of	Death		leg. No. Z U	1 41140
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9	Examir	er	4a. Facility Name (if not institution, giv	e street and number)		4b. City, Town, o	or Location of Death		4c. County of D	lhimal E
I	Funeral		Social Security Number 6. 8		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		Birthplace (State or Foreign
	Director			I □ M 2 🖫 F	85 Yrs.	Months Days	Hours Wiln.	(Month, Day,	1:925	Country)
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	or 28		10e. Street and Number			10f. Zip Code		1	10g. Citizen of What	Country?
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	3108 CORNW	all Road	/	818	33		USA	
	death item ner m		11. Marital Status	12. Was Decedent Ev	ez in U.S. 13.	Was Decedent of I	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Al Black, W	merican Indian,
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<u><u>ä</u></u>	Page nent ant; II ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Crestlan	N	/	7/2011	Marriotsvi	1/e, MA
Baltimore,	permit. Page 1 and 2 sh Department of Health a Important; If item 27 is any injury or other trau		21. Signature of Furneral Sérvice Lice	900		2. Name and Addre	100	adley	- Askto,	V FUNERAL
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19.	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	c						
9	be executed sician and burial-transi	calE	resulting in death) Last	Due to (or as a	consequence of):					
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68	certifi nding use a	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		7			23d. Date of	delivery
Box	death e atte ed for	Physician/Medi	in the past 12 months? 1 Yes 2 No	4 Pregnant at t	Fetal death 3 I ime of death 5 I	Other (specify)	cy		Month	Day Year
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σ,	es that signed	d by	Tart II. Other significant conditions	ontributing to death but	Thor resulting in the t	andenying cause g	ven in rait i.			Probably 4 Unknown
ord	requii been shoulk	Completed						24a. Was ar		autopsy findings available
ecc	The faw ate has page 2	duc						autops perform	y prior 1	to completion of cause of
al H	an: Tr		25. Was case referred to medical			26. P	lace of Death (Check		2'L No. 1 L	Yes 2 No
Vit	Physician: T r this certifica eral director, p	To B	examiner? 1 Yes 2 No	Hospital: 1 hpatier	t 2 ER/Outpatie	Lott	4		ence 6 Other (Sp	ecify)
of	ing Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,		wor	k?	28d. Describe ho	w injury occurred	
ion	ttendi death stor: A the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not I	00	A b b a section of the section of th		Yes 2 No	0061 11 10		2 42 4 11 44
Division of Vital Records,	l or A	Cer	4 Homicide determined	building, etc.	/ - At home, farm, str (Specify)	eet, factory, office		28f. Location (Str City or Town		Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Medical		rsician: To the best of m						
	he Ho iin 24 he Fu ipletel	Med		niner: On the basis of exa se Practitioner: To the b						ne cause(s) and manner stated. er as stated.
	To t		29b. Signature and title of certifier of SRy Ap M	UM·O -		29c. Licens			9d. Date signed (Mo	
							005746)	12/10	7/1
	5		30. Name and address of person who	W.D. 28	355min 1	V 520	3 30	altimor	e MD 2	1209.
	Stat	_	31. Date filed (Month, Day, Year)	32. egiotrar'	s Signature		,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Gilbert Charles Willett Physician/ December 19, 2011 8:40 \mathbf{P}_{M} Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg Montgomery 200 Washington Grove Lane . Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days Hours (Month, Day, Year) 217-44-7568 Director 1 ፟ M 2 □ F 65 Dec. 10, 1946 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 200 Washington Grove Lane 20877 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Examiner Black, White, etc. 0 ρ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Security Systems Service Manager 12 other Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic ever once. Lorraine Grace Zauzig Gilbert Francis Willett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Norton Willett/Wife 200 Washington Grove Lane, Gaithersburg, Maryland 20877 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) December 23, Mt. Zion Cemetery Bethesda, Maryland 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licensee Bethesda-Chevy Robert A. Pumphrey Funeral Home/ Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pancreatic Cancer Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or sails consequence of) If any, leading to immediate cause. Enter Underlying the burial-transi-Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No g Unknown g Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 🛛 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only o 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 20, 2011 D3313830. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Jaller, M.D. 19500 Amaranth Drive, Suite B, Germantown, Maryland 20874 31. Date filed (Month, Day, Year) State 2 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GENEVIEVE YARISH DECEMBER 11:00 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARFORD BEL AIR AVONDALE ASSITED LIVING If Under 1 Year I If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 153-14-9879 1 □ M 2 F **Director** 88 APRIL 28,1923 NEW JERSEY show with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f HARFORD BEL AIR MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 21014 108 REGENT DRIVE USA Page 1 and 2 should be filed within 72 hours after death al Hygiene.
d other than "natural", or items
event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates. Maryland 21215-0036 Specify: WHITE 1 Yes 2 XNo Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, ionce. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ ANTHONY NIZBORSKI MARCELLA YURCZYSZYN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 REGENT DRIVE BEL AIR, MD 21014 RICHARD YARISH-SON altimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 \square Donation 5 \square Other (Specify) 12/20/2011 BALTIMORE, MARYLAND ATLANTIC CREMATORY Signature of Funeral Service Linensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME D 610 W. MACPHAIL ROAD BEL AIR, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ CHP disease or condition Medical resulting in death) Due to (or as a consequence of) **E**xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 DNO 1 🗌 Yes Yes Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence Other (Specify) ASST. LIVING 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury after death. 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Decombos 17 2011 035516 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6.5 W. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

DHMH 17 Rev 1/2001

Registrar

DEC 07 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 00:56 Joyce Marie Adkins Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HIUMICO KEGIONAL If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year **Funeral** (Month, Day, Year) Hours 214-52-0271 62 1 □ M 2 🗓 F **Director** Sept. 10,1949 Delaware items 23a or 28a-f show 10d. Inside City Limits 10a State 10c. City, Town or Location at Director Examiner must be notified 1 X Yes 2 No Maryland Wicomico Sharptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21861 304 Water Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14 Bace - American Indian. 1. Marital Status or i þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Beauty Shop Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Margaret Arzilla Massey William Charles Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau O. Box 141, Sharptown, Maryland 21861 Robert C. Adkins/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sharptown Firemens Cem. 12/12/2011 Sharptown, Maryland 4 Donation 5 Other (Specify) Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 eral Service ations the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) meumonio Medical a consequence of Due to (or **Examiner** Sequentially list conditions Due to (or as a conseque ce of) Examine if any, leading to immediate
Cause (Disease or injury OPD or Attending Physician; The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Pregnant at time of death Unknown the 9 Unknown by 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed I page 2 should be det ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed' 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 Funeral Director: After this etely filled in by the funeral di 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending death. Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

Registrar
DHMH 17 Rev 06-2011

State

Day, Year)

31. Date filed (Month

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E. Carrull St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 9 James Elias Armstrong Nov. 20°11 11:27A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital Mary's Leonardtown St. 9. Birthplace (State or Foreign Country) MD Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 1 🙀 M 2 🗆 F 0973071957 Director 219 72 2522 54 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21268 Mayfair Lane #204 USA 20653 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Black 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry
St. Mary's Co. 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Public Schools Building Service Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Scriber James Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances R. Armstrong/Wife 21268 Mayfair Lane Lexington Park, MD 20653 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Sacred Heart Cem. 12/9/2011 Bushwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral ServicenLigensee 22, Name and Address of Facility Briscoe-Tonic Funeral Home 20601 2294 Old Washington Rd.Waldorf, 23a. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ to cardicalmonery Vandrianlar stenditill secondary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner dilated Cardianupone Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the burial-transit that the death certificate be executed Sci Zure and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Vear Day Pregnant at time of death Yes 2 No g Unknown 1 L Yes 2 L 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsv performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00068540 29

Registrar

State

Hespital

Mary 1

32. Registrar's Signature

BR

25500 Pt Lockset Pd

MA 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rinhart M

08

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Marie Meade Balderson Physician/ December 2 2011 9:28 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death, Millersville Knollwood Manor Anne Arundel 8. Date of Birth (Month, Day, Year) Nov. 3, 1926 Social Security Number 407–22–1647 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2XX Months Days Min. Hours Kentucky Director Usual Residence of Decedent 28a-f show 10a State 10b. Counts 10c. City. Town or Location 10d, Inside City Limits ems 23a or 28a-f sh r must be notified a Funeral Director Maryland Anné Arundel Annapolis 1XXYes 2 No 10e. Street and Number 165 East Bay View Drive 10f. Zip Code 10g. Citizen of What Country? 21403 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ㅎ ģ 1 Never Married 2 Married X Yes 2 N Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: "natural", Completed | If Yes, Give 1942-45 3XXWidowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 2 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Underwriter Insurance Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Thomas J. Meade Fannie Farlev 1 and 2 should be Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gayle Balderson/daughter 402 Peach Court Annapolis, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 1 XX Burial 2 Cremation 3 Removal from State Lakemont Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 12/7/2011 Davidsonville, Maryland 21. Signature of Funeral Berviele Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ance disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 3 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 9 Unknown the a P.O. I s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy Hospital or Attending Physician: The performe death? this certificate 2 Yes 25. Was case referred to medica Division of Vital Be 26. Place of Death (Check only one) examiner? ျာ 1 🗆 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🔲 Yes Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu nd title d 32036 PX who completed cause of death (Item 23a) (Type Prin 30. Name and address of 20 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

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		For Amend #8 per State of Maryland / Department of Health and	Mental Hygiene ZUII 41132
		1 - State Registrar FD, DOR, 12/6/11, LDB Certificate of Death	Reg. No.
Physic Mec			2. Date of Death Month Day Year 2126 M
Exam			
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 for	
Directo		220-68-8164 1 M 2 WF 55 Yrs. Months Days Hours Mir	S. B. Date of Birth 1056 (Month, Day, Year), 1758 (Month, Day, Year), 1758 (Mary Yland)
Maryland 28a-f show otified at	ctor		10d. Inside City Limits 1 D Yes 2 □ No
r 28a	Dire	MV Dorchester Cambridge 10e. Street and Number 10f. Zio Code	10g. Citizen of What Country?
ING 21213-UU36 MLL Filled within 72 hours after death with the Maryland ttal Hygiene. ad other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Funeral Director	816 Maces Lane 2/613	25A
deat deat			Specify Yes or No- rto Rican, etc.) 14. Race - American Indian, Black, White, etc.
nd Z1Z15-UU36 filed within 72 hours after al Hygiene. I other than "natural", or went, the Medical Exami	ed by	1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give Year or Dates.	Specify: Black
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TZT thin 7 ene. than	Completed	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired)	a tech Care Provider
G K ed wi Hygir other ent, tl	Be		g tech Care Provider ame (First, Middle, Maiden Surname)
<u>ග්දෙන්</u> ව	2		e Mae Conway
Maryla 2 should be th and Men 7 is marke traumatic			Rural Route Number, City or Town, State, Zip Code) 21643
□ □ □ □ □ □		Ella Brown 4820 Skinners	Run Rd. Hurlock, MD.
<u> </u>		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore, permit. Page 1 and Department of Her Important: If item any injury or othe		4 Donation 5 Other (Specify) John Cemetery 12	10/11 Preston, Maryland
baltimo		21. Signature of Funeral Service Licensee 22. Name and Addres of Facility Henry Funeral	Home, RA. on St. Cambridge MD. 216/15
		23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ac or respiratory arrest, Approximate
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Hostenstine Covenar Vascular	Interval Between Onset and Death Value
Medica	1	disease or condition resulting in death) a. Hue to (or as a consequence of):	aiseare years
Examine		Sequentially list conditions, b.	
p #s	Examiner	If any, leading to immediate cause. Enter Underlying	
ecute and I-trans	Exar	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of):	
be ex sician	cal	d	
66 / 6 ertificate ding phy se as the	Med	IF FEMALE.	
x ox h cert tendir r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery
box e death the atter	by Physician/Medi	1	Month Day Year
that the	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
uires t n sign	ed b	cerebral vascular disease	1 Yes 2 No 3 Probably 4 Unknown
OT VICAL HECORGS, ng Physician: The law requires ter this certificate has been signeral director, page 2 should b	Completed	dia betes	24a. Was an autopsy findings available prior to completion of cause of
The la	l m		performed? death? 1 Yes 2 No 1 Yes 2 No
ctor,	Be (25. Was case referred to medical 26. Place of Death (Ch	neck only one)
Physic Physic this c	ြု	1 Yes 2 No 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing	Home 5 X Residence 6 ☐ Other (Specify)
ding F ding F After funer	cate	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury work? 28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred
DIVISION tal or Attendir s after death. s Director; Af ed in by the fu	Certificate:	Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined determined	28f. Location (Street and Number or Rural Route Number,
DIVISION OT VITAI RECORDS, P.O. BOX 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit			City or Town, State)
ie Hosp n 24 ho ie Fune oleted f	Medical	29a. Certiffier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred only one) 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, only one)	, and due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s) and manner stated. blace, and due to the cause(s) and manner as stated.
To the within	-	29b. Signature and title of certifier Wo nut 7 29c. License number	29d. Date signed (Month, Day, Year)
J.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	December 1, 2011 Oyal dak, Md 21662
- 0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	() 1 M / 2/1/2
V		David Brandon 5500 Andersy Hall Rd. Al	yal oak, Ma Libbl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 22. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2011 10:30P M <u>Ellen Burnette Boutelle</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Middletown9012 Old Hagerstown Rd. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 919 Months Hours Min Country) 219-44-4863 Usual Residence of Decedent Director 1 🗆 M 2 😾 F 92 iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director MD Frederick Middletown 1 Yes 2 No 10f. Zip Code 21769 10e, Street and Number 10g. Citizen of What Country? USA Funeral 9012 Old Hagerstown Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White nan "natural", o Medical Exan If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry 12 should be fileo w....alth and Mental Hygiene.
m 27 is marked other than "n (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Blanche Lewis George Thomas Burnette Department of Health and Important: If item 27 is many injury or other traumany injury or other traumance. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26568 E. Bonefield Rd., Oxford, MD 21654 Edward Bishop Jr. (Son) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Smirtysburg Crematory 12/5/11 Smithsburg, 1 Burial 2 Cremation 3 Nemoval from State Donation 5 Other (Specify) Sign ture of Fineral Series licens ²² Donald B. Thompson Funeral Home 18 Middletown, MD 21769 23a Part 1. Ent if the disease, or complications shock, or if art failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Ca ne (Final Physician/ -multi-inta disea or condition resulting in death) ementia Medical **Examiner** atheroscleros Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence on the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by strictures 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♠No 24a. Was an and performed? Cancer, Coronary I or Attending Physician: I after death. funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 1 Inpatient 2 I ER/Outpatient 3 -27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0043389 December 5 completed cause of death (Item 23a) (Type, Print) 30. Name and address o 10 Deluc 31. Date filed (Month, Day, Year 32. Registrar's Signature State 2011 Registrar

DHMH 17 Rev 06-2011

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2011 11:00 P M December Bernice Ward Bowers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Williamsport Homewood Retirement Center 8. Date of Birth (Month, Day, Year) July 24,1919 If Under 1 Year | If Under Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Maryland 214-09-7409 92 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experiment must be notified at 1 ☐Yes 2X No Director Williamsport Maryland Washington death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21795 USA 16505 Virginia Ave. C-234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race · American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Heating Wholesale 12 Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Clayton Elmer Irene Agnes Neikirk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is any Injury or other traunonce. 9802 Woodside Ct. Hagerstown, Maryland 21740 Fran Wishard - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) Rest Haven Cemetery Dec.14,2011 Hagerstown, Maryland 4 ☐ Donation osobrned frometalityHome, P.A. 425 S. Conococheague St. Williamsport, Maryland not enter the mode of dying, such as cordiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** GA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Occase of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and bunal-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal one) and manner stated. within 2. the 29d. Date signed (Month. Dav. Year) 29b. Signatu 29c. License number 2 (Item 23a) (Type MACONTRUN Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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amend 17, 18, per fh, 9922 12-22-11 sm.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12:45 AM 12 Month Physician/ 2011 PK Jean Ellen Bloom Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Transitions Healthcare Sykesville If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** (Month, Day, Year) Hours Min. 034-12-6252 87 **Director** 1 □ M 2 XE MA 03/31/1924 Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director Carroll Finksburg 1 🗌 Yes 2 🕱 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21048 USA 2535 Cornstalk Road within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. the Medical Examiner Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD State Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is many injury or other. ဂ Ellen Curtis Ellen McGrath Lawrence McCrath Lawrence Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Westwood Circle, State College, PA 16803 Richard Brennan/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗶 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul Luth. Cem. 12/19/2011 Belcamp, MD Pritts Funeral Home and Chapel Signature of Funeral Service Licensee 22. Name and Address of Facility K 412 Washington Road, Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 bother for Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Die to for as a consequence of if any leading to immedicause. Enter Underlying burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 use as the yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death been signed by the salvould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an filled in by the funeral director, page 2 autopsy perform Renterous Yes 2 NO 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 10 Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner 28a. Date of injury (Month, Day, Year) Deatl 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check within 2 only one) 29b. Signature and litle of certi-29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 824 Washington Ernesta Men (29 31. Date filed (Month, Day, Year) M . D. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DEC. 14, 2011 GEORGE CHARLES BORNSCHEUER 9:35A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MORNINGSIDE HOUSE WALDORF CHARLES If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 2-24-1922 Social Security Number **Funeral** 9. Birthplace (State or Foreign Min. 1 ★ M 2 □ F Months Country) Days Hours 060-14-6375 89 Yrs Director N. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES WALDORF 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 70 VILLAGE STREET 20601 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Ves 2 No NAVY
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify SpecifyWHITE 3 Widowed 4 Divorced Completed Year or Dates WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEERING CO'S. CIVIL ENGINEER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 CHARLES BORNSCHEVER SUSANE SEELINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN DOWELL-DAUGHTER 7315 AQUINAS AVE. UPPER MARLBORO, MD. 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 1216-11 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00479 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Demen disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ing physician as as the burial-Physician/Medical Box 68760 signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 75.8 24a. Was an has autopsy perform Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral: 27. Manner of De Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 2 Accident 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner 3 🗌 Certifying Nurse only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D0033426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 2665 LaPlata / LAGrange 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ SANDRA BE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Northwest Hospital Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 219-58-4744 1 🗆 M 2 💢 F Director Yrs. Maryland 61 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Funeral Director 1 Yes 2 X No Randallstown MD. Baltimore 10g, Citizen of What Country? 10e. Street and Number 21133 United States 9207 Liberty Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Horse Farm Farm Hand 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Charles Baublitz Gertrude 19a. Informant's Name/Relationship (Type, Print) (Husband, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 Randallstown, Maryland 9207 Liberty Road Paul V. Bennett Jr. Baltimore, Date 15, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec. 1 Burial 2 Cremation 3 Removal from State Hampstead, Maryland 4 Donation 5 Other (Specify) Carroll Cremation 2011 E.G. Kurtz & Son Funeral 22. Name and Address of Facility Jarrettsville, Maryland Home. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are unitiated events.) Examiner Due to (or as a consequence of) that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) n signed by the at ald be detached fo 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform eral Director: After this certificate filled in by the funeral director, pag To the Hospital or Attending Physician: 25. Was case referred to p 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending after death Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature and title of certifie e and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 05 Cunningham 02:48 AM Nancy Ruth 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Months Hours Min (Month, Day 71 Director 10 1940 Maryland 216-38-0946 July Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director 1 Yes 2 XNo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n with 1 Funeral 21740 U.S.A. 941 Kenwood Drive items 2 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Black White etc o ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+ 12 Administrative Assistant Board of Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ပ Mary Virginia Taylor injury or other traumatic Woodrow Wilson Cronise Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauone. Keith L. Keefer/Son 18830 Island Drive, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Boonsboro Cemetery 12/10/2011 Boonsboro, Maryland of Funeral Service Licens 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ obstr Whomle Years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of Exam burial-transit and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>수</u> Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Yes Yes should Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2 s has 24 hours after death. Funeral Director. After this certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 🕰 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 🖄 Natural 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ 28365

State Registrar

IW-10

30. Name and address of person who completed cause of deat

31. Date filed (Month)

I sheet Hagestein M D21790

(Item 23a) (Type, Print)

32. Registrar's Signature

36

11-09403 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Hazel Eugene Callahan 1- For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 14, 2011 0819 hrs **Medical Examiner** Hazel Eugene Callahan 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Talbot 11380 Longwoods Road 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs Director 217-30-7548 82 11-18-1929 Country) MD 1XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 X No "natural", or items 23a or 28a-f show Examiner must be notified at once, MD Talbot Easton filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11380 Longwoods Rd 21601 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 X Yes If Yes, Give Year or Dates: 3 Widowed 4 X Divorced 1 Yes 2 X No specify: Specify: White ě 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na injary or other traumatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture 11 Salesman 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alton Nicholas Callahan Margaret Favinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ Mollie C. Scharnus 808 Thompson Creek Rd Stevensville MD 21666 (Niece) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Cem. 1 X Burial 2 Cremation 3 Removal from State Joseph's Church 12-19-2011 St. Cordova, MD Donation 5 Other Specify 21. Signature of Funeral Service Lidensed Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison St. Easton MD 21601 100 S. Harrison St. Easton MD 2160 Riogs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a Part Poter the disease of complica Physician Between Onset and failure. List only one cause on each Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last, attending physician and or use as the burial - transit Physician/Medical X UNPENDED AMENDED 23a, pt.II, 27, per me, g924 2-7-12 sm Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy 1 Live birth Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 6 1 Yes 2 No 3 Probably 4 V Unknown Metastatic cancer; diabetes mellitus; chronic obstructive Completed this certificate has been a 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Pulmonary Disease autopsy death? ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) the Hospital or Attending Physician: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred After 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural 1 Yes 2 No 5 Pending Director: d in by the f death. Accident 2 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after 3 Suicide Could not be or Town, State) within 24 hours at To the Funeral L 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 15, 2011

31. Date filed (Month DEC) State 19 2011 Registrar

Russell Alexander MD.

Assistant Medical Examiner oistrar's Signature 32. R4

30. Name and address of person who completed cause of death (Item 23a)

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depa			-			
		. '		ificate of Death	Reg. No. 2	1 41161			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Yea	3. Time of Death			
, alecco	Medic Examin		FRANK JOSEPH CAVASINA 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	DEC 05 201				
	EXAMI	ier	GILCHRIST HOSPICE CARE	TOWSON	BALTI				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. (Month, Day, Year)	Birthplace (State or Foreign Country)			
	Director s		217−26−1630 Usual Residence of Decedent 1 ☑ M 2 ☐ F 80 Yrs.		11/06/1931	MD			
	ryland -f sho ied at	ctor	10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits 1 Yes 2 No			
	ne Mar or 28a r notifi	Director	MD BALTIMORE ESSEX 10e. Street and Number	10f. Zip Code	10g. Citizen of What				
	with the s 23a ust be	Funeral	8802 GOLDENTREE LANE	21221	USA				
	death r item iner m		11. Marital Status 12. Was Decedent Ever in U.S. 13. W Armed Forces? If	as Decedent of Hispanic Origin? (Spo Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.) 14. Race - A Black, W	merican Indian, hite, etc.			
036	s after ral", o Exam	ed by	1 Never Married 2 Married 1 Yes 2 No 1952 If Yes, Give 1954	Yes 2 No Specify:	Specify: \	WHITE			
21215-0036	2 hour "natu edical	Completed	15. Decedent's Education 16a. Decede	ent's Usual Occupation and of work done during most of work	16b. Kind of Busine	ss/Industry			
121	rithin 7 iene. r than	Com	Flementany/Secondany (0, 12) College (1, 4 or 5.) life. DC	NOT use retired) RICT MANAGER	CANNON	SHOE			
pu	filed wall Hyg	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	(First, Middle, Maiden Surname)				
Maryland	uld be I Ment narke natic e	T ₀	PATSY CAVASINA		TACCONELLI				
ă Z	12 sho llth and 27 is r r traun		The state of the s	Address (Street and Number or Rura DIMAR DRIVE, N		Zip Code) 21771			
ore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rightry or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition		Date 20c. Location - City				
Baltimore,	t. Page tment tant: I		4 Donation 5 Other (Specify) STAUFFER	CREMATORY 12	07/2011 FREDE	RICK, MD			
Bal	permit Depar Impor any in			Name and Address of Facility LTON FUNERAL I	P.O. BOX 8	B6 LE, MD			
۲	Я		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac	r respiratory arrest,	Approximate Interval Between			
**	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Subda Neuralom Onset and Death Occurs						
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	de he led	hysi	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)	.,,,				
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\leq	Physic this ce ral dire	၉	1) Yes 2 No 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing Ho	me 5 Residence & Other (So	pecify) Na 30 (Co			
0 0	iding f th. : After e funer	cate	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 27. Accident Investigation 28a. Date of injury (Month, Day, Year) 1 ☐ Novamber 2 ☐ 24b. Time of injury (Month, Day, Year) 1 ☐ Novamber 2 ☐ 24b. Time of injury (Month, Day, Year)	WORK?	28d. Describe how injury occurred P	Tobable, Idil			
/iSio	r Atter ter dea rector by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		28f. Location (Street and Number or City or Town, State)	Rural Route Number,			
ă	pital o		home		3802 Goldentha 191				
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or investigned only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, or continuous transfer of the best of my knowledge, or continuous transfer or con	gation, in my opinion, death occurred a	the time, date and place, and due to t	he cause(s) and manner stated.			
	To the within To the comp	<	29b. Signature and title of certifier	29c, License number	29d. Date signed (Mo	onth, Day, Year)			
	^		Halling	1) 58303		ser 5 2011			
	ار.		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	- Charles ST	Ton son my				
	Stat	e.	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	a. el. 1					
	Registra	ir	BEG 0 12011 Sineur B. Go	West -					

						artment of Health and N		•		
			For State Registrar	State of Waryla	-	tificate of Death		.No. 2011	41162	
4	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death	
, m	Medic	al	Barbara Jo. Co. 4a. Facility Name (if not institution, give st.	laciello		I	December		5:26A ™	
	Examir	er	Fort Washington I			4b. City, Town, or Location of Death Fort Washington		4c. County of Death Prince Ge		
	Funeral Director		5. Social Security Number 6. Sex 1 \square		. last birthday) 47 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Ye April 25,		place (State or Foreign Virginia	
	d iow	_	Usual Residence of Decedent 10a, State 10b, County	100.0	City, Town or Lo		1.2			
	arylan a-f sh ified a	Director	MD Charles		Waldorf				10d. Inside City Limits 1 ☐ Yes 2🌠 No	
	the M s or 28	I Dir	10e. Street and Number		wardorr	10f. Zip Code	10g	. Citizen of What Cou		
	th with ms 23a	Funeral	8613 Valley Drive			20603		USA		
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003	urs aft tural", al Exal		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1	I ☐ Yes 2 █ No Specify:		Specify: Wh	ite	
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212	within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5+)		al Records Admin.	Specialis	t Federal	Govt.	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Atelio Meale			18. Mother's Nam Mary Rio	e (First, Middle, Maid S	den Surname)		
Man	shoul h and h 7 is ma		19a. Informant's Name/Relationship (Type	,		ng Address (Street and Number or Rura			Code)	
re,	Healt Healt tem 2		Joseph Colaciello/H 20a. Method of Disposition	20b.	Place of Dispo	Valley Drive, Wa	Date 20	20603 c. Location - City or T	own. State	
mo	Page nent of		¥ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State S	cemetery, cren t. Pete	natory or other place) rs Cemetery 12/1	0/2011	Waldorf,MD		
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	M00945	100	Name and Address of Facility AREHART-ECHOLS FU			.0646	
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the dec	ath. Do not ente	211 St. Mary S Aver the mode of dying, such as cardiac c	e. La Pla or respiratory arrest,	ta,MD	Approximate Interval Between	
7	Pnysician/ / Medical		Immediate Cause (Final disease or condition resulting in death)	Cardsax		rest			Onset and Death	
	Examiner		f	Due to (or as a conse	quence of):	1/4				
	_ +	iner	Sequentially list conditions, b. if any leading to in resolute cause. Enter Underlying	Ouvito (or as a conso			1			
	be executed sician and burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a conseduence of):							
00	be e siciar buria	g								
687	eath certificate t attending physi I for use as the t	/Me	IF FEMALE:	c. If yes, outcome of pregr	nancv				-	
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of g ☐ Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of delive	Day Year	
Division of Vital Records, P.O.	that thured by	by Pt	Part II. Other significant conditions cont	ibuting to death but not re	esulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?	
ds,	equires sen sig ould b						1 🗆 Yes	2 No 3 Pro	bably 4 🗆 Unknown	
OS CO	law re has be je 2 sh	Completed					24a. Was an autopsy performed	prior to co	psy findings available empletion of cause of	
<u>~</u>	an: The tificate or, pag		25. Was case referred to medical			26. Place of Death (Check	1 🗆 Yes 2 🗀		2 🗆 No	
Ĭ,	hysicia nis cer I direct	10 B	examiner? 1 ☐ Yes 2 → No	spital: 1 Inpatient 2	≰ER/Outpatien	Other		e 6 Other (Specif	()	
n of	Jing P h. After tl funera	ate:	27. Manner of Death 1/≝Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work?	28d. Describe how in	njury occurred		
isio	Attendar deat ector:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I		M 1 ☐ Yes 2 ☐ No eet, factory, office		t and Number or Rura	l Route Number,	
<u>.</u> ≥	urs after ral Dir			building, etc. (Speci			City or Town, Si			
	Hosp 24 ho Fune leted fi	Medical	(Check 2 \(\sum \) Medical Examine	: On the basis of examination	on and/or invest	occured at the time, date and place, an igation, in my opinion, death occurred at leath occurred at the time, date and place	the time, date and p	lace, and due to the ca	use(s) and manner stated.	
	To the within To the comp.		29b. Signature and title of certifier	Tabligher. To the best of f	ny knowledge, c	29c. License number		Date signed (Month,		
			1/6	~		065385		12, 7	2011	
P	0-2		30. Name and address of person who com	_		rint)	Fect W	allento-	20244	
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Sign		ake	1 1	uniy	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LESLIE VANESSA CARSON DEC. 11:40 PM 02 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours JUNE 1 577-76-3913 Director 56 1 □ M 2**XX** WASH., D.C. Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director r 28a-f s notified XX Yes 2 No N/A WASHINGTON, D.C. N/A 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 20032 23a UNITED STATES with 3232 12TH STREET S.E. death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ò þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after altimore, Maryland 21215-0036 BLACK 1 Yes 2XXIo Specify Specify: "natural" Completed 3 Widowed 4 X X ivorced Year or Dates the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired)
SPECIALIST FOR FACILITY
PLANNING 16b Kind of Business/Industry
DEPART. OF MENTAL
HEALTH
(D.C. GOVERNMENT) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12TH YEARS event, Be 17. Father's Name (First, Middle, Last) nt of Health and Mental Hit: If item 27 is marked other or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ROBERT L. CARSON DOLORES C. SAMUELS CARSON 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address Street and Number or Rural Route Number, City or 10wn, State, 219 5000, 3232 12TH STREET S.E., WASHINGTON, DC (Street and Number or Rural Route Number, City or Town, State, Zip Code, LAUREN A. MAY / DAUGHTER 20032 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State DEC. 2011 09, 1 XX rial 2 Cremation 3 Removal from State ò Department Important: If any injury of once. RESURRECTION CEM. CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility
TERRENCE L. JOHNSON FUNERAL S
4433 WHITE PLAINS LANE, WHITE 21. Signa of Funeral Service License Johnson SERVICE, TERRENCE L. JOHNSON#M00993 4433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ADVANCED BREAST CANCER Immediate Cause (Final Onset and Death Ph. i. i. n disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 XXIo Month Day Year Pregnant at time of death Unknown be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2XX to the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in hearth. 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2XXVo Other: ျပ 1 XX patient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending work' 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🛮 Xartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 12,05,2011 65 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FARZAD MALEKANIAN, M.D., 1500 FOREST GLEN RD., SILVER SPRING, MD 20910 31. Date filed (Month, Day, Year) DEC 0 8 2011 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Amend #26. Per Phys. PGC 12-8-11c Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day 30 Year Co1e Dora Koroma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Takoma Park 505 780 Fairview Avenue: Apt. 9. Birthplace (State or Foreign Country West Africa Sierra Leone If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 X Min May 12, Year 929 82 Director 217-33-5738 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director must be notified 28a-f 1 X Yes 2 No Maryland Prince Georges Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö West 23a Funeral 20912 6735 New Hampshire Avenue; Apt. 304 Sierra Leone, Africa ral", or items? Examiner mus death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. o 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify **Black** Specify: "natural", 3 X Widowed 4 Divorced Year or Dates Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me lementary/Seconday (0-12) College (1-4 or 5+) Domestic 12th grade Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Yanabureh Kamara Pa Amadu Koroma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 6735 New Hampshire Avenue; Apt. 304; Takoma Park, 20912 John Kenneth Edwards (Son) 20a. Method of Disposition 20c. Location - City or Town, State West 20b. Place of Disposition (Name of cemetery, crematory or other place) o = p X Burial 2 Cremation 3 Removal from State Dec.16,2011 Department of Important: If any injury or Kissy Road Cemetery Sierra Leone; Africa 4 Donation 5 Other (Special) Sonature of Fureral Servi 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Arteriosclerotic Immediate Cause (Final pertensive Herro Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicisted filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 ☐ Yes 2 ₺ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2+ Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home esidence 6 X Other (Specify Daughter's ၉ 1 Inpatient 2 ER/Outpatient 3 DOA House 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred ☐ Natural injury 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 🛮 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the within To the 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVAder 32. Registrar State 8 2011 DEC 0 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per me, g922,12/16/2011dhb Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Wenh 3:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical eritus enter Washingtor 42gers town Security Number **Funeral** Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, 1 X M 2 🗆 F Months Hours Min Director 168-36-8621 63 1947 Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State Director 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Franklin Mercersburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3559 Lemar Road 17236 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give 1 C Baltimore, Maryland 21215-0036 Year or Dates. 1968-70 1 ☐ Yes 2 🔽 No Specify: 3 Widowed 4 X Divorced Specify: White any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) mportant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Meat manager Grocery Be permit. Page 1 and 2 should be filed be be been becard. Department of Health and Mental Hyo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Ned R. Cordell Sarah R. Amsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nichole R. Cordell/daughter 13934 Green Mountain Dr., Maugansville, MD 21767 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Genetery, crematory or other place)
Geisel Funeral Home
and Crematory 1 Burial 2 X Cremation 3 Removal from State 16, Nov 4 Donation 5 Other (Specify) Chambersburg, PA Signature of Fune al Service License 22. Name and Address of Facility Lininger-Fries Funeral Home Inc 47 N. Park Ave., Mercersburg, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a co Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine use as the burlal-tran that initiated events resulting in death) Last that the death certificate be execu Due to (or as a consequence been signed by the attending physician should be detached for use as the burlal Physician/Medical MAPPROVED BY Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death by) not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an funeral director, page 2 autopsy performed? Yes 2 Ne Hospital or Attending Physician: The 124 hours after death.
Funeral Director: After this certificate h 2 No 1 Yes Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes ျှ Other 1 Inpatient ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury Accident Investigation Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Hornicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 dnly one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month.

16

2011

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December AM Phyllis Ann DELLINGER 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 26 1949 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Country) Maryland **Director** 62 220-54-2765 Usual Residence of Decedent show 10a. State 10b. County death with the Maryland aţ 10c. City. Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Yes 2X No Maryland Washington Hagerstown 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 17500 Old Stone Court 21740 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🛛 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give 3 Widowed 4 X Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Shipper Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Telitha Younker Marvin L. Shives 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Linda Shives-Sister-In-Law</u> 14557 Mercersburg Road, Clear Spring, Md. 21722 Department of Heall Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ r 4 □ Donation 5 □ Other (Specify) Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park | 12/10/2011 | Hagerstown, Maryland Signature of Funeral Service L 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final metastatic cholangiocancinoma Physician disease or condition resulting in death) Medical Due to (or as a consequence of); **Examiner** arndies Sequentially list conditions, Examine if any, feating to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on attending physician and for use as the burial-transit nemia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year signed by the a d be detached for 1 Yes 2 g 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been venous Thrombosis of Extremetics 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ၉ ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of ne Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARID JW-7 MUNSHED

State Registrar 31. Date filed (Monti

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylar				d Mental Hy	giene		
			1 - State Registrar Certificate of Death						Reg. No. 2011 4115		
	Physicia	-,	1. Decedent's Name (First, Middle, Las			2. Date of De Month	Dav Ye	3. Time of Death			
	Medic	al	John Robert Da					Decem		11 1115 M	
	Examin		ta. Facility Name (if not institution, give	Hospital		4b. City, Town, o	Ston If Under 24		4c. County of I	Death Location Birthplace (State or Foreign	
3	Funeral Director		5. Social Security Number 219-46-4930 Usual Residence of Decedent	ex	last birthday) Yrs.	If Under 1 Year Months Days		lin. 8. Date of Bir (Month, Da 0ct. 3	y, Year)	Country) ennsylvania	
pup	show	tor	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits	
No.	28a-f notifie	Director	Maryland Caroline	e De	nton	10f Zin Codo			10g, Citizen of Wha	1 Yes 2 X No	
2	23a or st be r		10e. Street and Number 6328 Laurel Grove	Road		10f. Zip Code 21629			USA	at Country?	
6 Ter death w	perint. Tage I and 2 should be more writing in the properties of the state of the state of the properties of the properties of the state of the stat	by Funeral	11. Marital Status 1 ☐ Never Married 2 🏋 Married	12. Was Decedent Ever in U Armed Forces? 19 1 Xyes 2 No	967-	Vas Decedent of F Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)		American Indian, White, etc.	
John 21215-0036 within 72 hours after	atural"	eted	3 Widowed 4 Divorced	Year or Dates.		lent's Usual Occup			16b. Kind of Busin	White	
John 1215-00:	an "na Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)	(Give	kind of work done O NOT use retired,	during most of)	working			
))	ygiene her th t, the			College (1-4 or 5+) 5+	State	PoliceO			Law Enfo	rcement	
/S/ /land	Vental Hy arked ott	To Be	17. Father's Name (First, Middle, Last) Wilmer Paul Davis	3			Helen		th McGeeh		
$\sum_{\alpha \in \mathbb{N}} S_{\alpha} \le 1$	alth and n 27 is m er traum		19a. Informant's Name/Relationship (7) Nina Davis/Wife	ype, Print)	19b. Mailir 6328	Address (Street	and Number of Grove R	Rural Route Number	er, City or Town, State on, Maryl	e, Zip Code) and 21629	
more,	ent of He nt: If iten ry or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	cemetery, crer	sition (Name of natory or other pla ns Cemete	م م أ	Date /5/2011	20c. Location - Ci Beulah,		
Baltin	Departm Departm Importa any inju		21. Signal to of Funeral Service Lice			Name and Addre eller Fui 06 Main	ess of Facility neral H Street,	ome, P. O East New	Box 207 Market,	MD 21631	
			234. Part 1. Enter the disease, or com abock, or heart failure. List only	plications that caused the dea						Approximate Interval Between	
P	hy ician/ Medical Examiner		Immediate Cause (Final disease or condition ACUTE PULMON ARY EMBOLISM a							Onset and Death	
			resulting in death) Due to (or as a consequence of): ARTERIAL THROMBO EMBOLISM								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse							
cuted	and -transi	Examiner	cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as a consequence of):								
60	hysician and the burial-transit	dical E	resulting in death) Last	d ACWIE RE	,	N SUFFIC	HENCY				
Box 6876	attending phy	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy		-		23d. Date	of delivery	
. Box	y the atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of	f death 5 [Other (specify)	icy		Month	n Day Year	
s, P.O.	been signed by the s		Part II. Other significant conditions of ESOPH A-GEAL		iven in Part I.			ute to the cause of death? Probably 4 Unknown			
Division of Vital Records, P.O. Box 68760	scertificate has been director, page 2 shou	Completed by	ESOPH AGEAL PHARYNGEAL	CANCER				perf	opsy prie	ere autopsy findings available or to completion of cause of ath? Yes 2 \sum No	
<u> </u>	ificate or, pa	e Co	25. Was case referred to medical	,		26. I	Place of Death	1 ∐ Yes Check only one)	2 № No 1	l Yes 2 □ No	
Vita	s cert direct	70 B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 🗆 DOA Ot	her: 4 🗌 Nursi	ng Home 5 🗌 Res	idence 6 🗆 Other	(Specify)	
n of V	th. After thi e funeral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident Investigatio	28a. Date of injury (Month, Day, Year)	28b. Time o injury	f 28c. Inju wo	iry at rk? ☐ Yes 2 ☐ Ni		how injury occurred		
Division Affer	after des Director d in by th	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ruccity or Town, State)							or Rural Route Number,	
Hospita	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Chook 2 Modical Evan	vsician: To the best of my kno niner: On the basis of examinat se Practitioner: To the best o	ion and/or inves	tigation in my opin	tion, death occu	rred at the time, date	and place, and due to	o the cause(s) and manner stated.	
<u>c</u>	within To th	=	29b. Signarure and title of certifier	*	Λ	29c. Licen	se number		29d. Date signed (Month, Day, Year)	
	ax		▶ K Mohan	171	د ا		6956		Dec, 01	12011	
-	9.		30. Name and address of person who Ravi Mohan, M.D.				t Foot	on MD 21	601		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature		r, East	41 ست و ۱۱۰	UUI		
	Registr		DEC 0.5.201	11 /2 Days	A bo	Mal					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Amend Item 25 State of Maryland / Department of Health and Mental Hygiene per me, g922, 12/16/2011 dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 November 1622 Ρм Tammy Rene Daniel Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Ceci1 E1kton Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (in vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 🗆 M 2 💢 F May 8, Year 963 221-46-1833 48 Maryland Yrs Director Usual Residence of Decedent 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number ō 10f. Zip Code 10a, Citizen of What Country? 23a Funeral 111 Eleanor Street 21921 United States items 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important! If item 275 marked of other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Press/Cable Operator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luther Richardson, Jr. Linda Keesev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert G. Daniel/Husband 111 Eleanor Street, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of Gracelawn Memorial Park 20c. Location - City or Town, State Date 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State December 4 ☐ Donation 5 ☐ Other (Specify) New Castle, DE 2011 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signatule of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Moxic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the burial-transit and that initiated events MEDICAL EXAMINE Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical that the death certificate be 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box 23d. Date of delivery Live Birth 2 L. recards
Pregnant at time of death Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) be detached 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes page 2 should has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? this certificate 1 Yes 2 No Yes 2L director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be the Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my point, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Sian re and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 044716 November 26, 2011

State Registrar 30 Name

239

WD

and address of person who completed cause of death (Item 23a) (Type, Print)

(Month, Day, Year)
NEC 1 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1913 David Gordon Drewry 2011 Medical 2 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional 'umberlan Alleganu 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral Director** 228-30-1117 82 1 **X** M 2 □ F March 9, 1929 Virginia Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 XYes 2 No Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12502 Henry Dr SW 21502 U. S. A. 12. Was Decedent Ever in U.S Armed Forces? 1951 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Maryland 21215-0036 1953 White 1 ☐ Yes 2X No Specify "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Hercules - ABL other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ Herbert James Drewry Inez (Bailey) Drewry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau David Drewry, Jr. Son 1111 Ivy Hill Dr., Middletown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Rocky Gap Veteran Cem 12/20/2011 Flintstone, MD 4 🗂 Donation 5 🗌 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, P.A. 1302 National Hwy., LaVale, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) FARS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DENTIA Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Tes Yes 2 AN To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural work? 5 Pending injury 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Practitioner: To the best of my knowledge, d 29b. Signature and title of co 29d. Date signed (Month, Day, Year) SN uma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year

DEC 2 1 2011

21502

Shiv C. Khanna, 1221 E. National Hwy., LaVale, MD

32. Registrar's signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🥎 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 15 2011 Physician/ 4:59 а м THOMAS ROBERT ELBURN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Chester River Hospital Chestertown Kent. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) Funeral Days April 1 Hours Min 1 **X** M 2 \square F 70 Maryland 218-34-8078 1941 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Examiner must be notified 1 Yes 2 No MD Kent Millington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 404 Back St. 21651 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black White etc. X Yes 2 □ No 1966 Yes, Give 1 Never Married 2 🙀 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced -1968 Year or Dates. 16b. Kind of Business Industry
Electric/Plumbing 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician/Plumber Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George C. Elburn Ellen Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) Millington, MD. 21651 Cindy H. Elburn 404 Back St. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 😾 Cremation 3 🗆 Removal from State njury or Kent Cremation Services 12/18/11 Smyrna, DE. 4 Donation 5 Other (Specify) 21. Si er I Service 22. Name and Address of Facility Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 M00510 Galena, Approximate Interval/Between Onset and Death e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cape on each line. K. or hear Immediate Cause (Final Physician disease or conditie neumonia Medical resulting in death Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the invertal director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been significate has been significated and funeral director, page 2 should f 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 은 ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 6 🗆 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) D16488 December 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne D. Benjamin, M.D.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2 1 2011

6602 Church Hill Rd.

32. Registrar's Signature

Chestertown, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 30,2011 Physician/ FOX KENNETH MARTIN WARREN 10:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Palomino | Middletown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 213-40-7052 1 **X** M 2 □ F **Director** Maryland Yrs OCT. 24,1944 67 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2X☐ No Maryland Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4187 Palomino Lane 21769 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Year or Dates.1962**–**63 White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Home Construction 12 Builder injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or att. W. Fox Ida Marie Rothenhoefer Kenneth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4187 Palomino La / Middletown, MD 21769 Virginia Burner / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dec.5,2011 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cem. Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home, 1621 Opossumtown Pike/Frederick, MD 21702 21. Signature of Funeral Service Licer Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ause on each line.

ANOTHER CELL LUNG: CANCER. Interval Between nset and Death heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) anding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I page 2 s autopsy perform to the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in hours. tor: After this certificate the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 9 No 1 🗌 Yes 4 Nursing Home 5X Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DCA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Accident Investigation 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and the of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (ax) W. SEVENTA ST. FREDER

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1251 PM DECEMIZER Russell L. Fanus 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center <u> Hagerstown</u> Washington 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 PA 24 Hrs 8. Date of Birth **Funeral** 1 😿 M 2 🗆 F Months Days Min Hours 67 8 8 1 1 9 4 4 **Director** 1<u>82-40-7268</u> Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits PA Cumberland 1 Yes 2 No Carlisle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral West Penn 17013 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1X Never Married 2 Married Maryland 21215-0036 Yes 2 **X**No If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: White 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Laborer Knouse Foods Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Russell K. Fanus Verna Shope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Stewart K. Fanus 116 Big Springs Terrace Newville, Pa. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HollingerFH/Crem 12/8/2011 Mt. Holly Spgs.PA Signature of Funeral Service Licer 22. Name and Address of Facility Hollinger Funeral Home&Crem 7 Strettle .Baltimore Ave.Mt.Holly SpringsPA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ andrac disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or linjury that initiated events Examine diovescular Disease attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death signed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy
performed?

Yes 2 1 No certificate 2 🗌 No 1 🗌 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a To the Funeral I Medical 🔀 crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number person who completed cause of death (Item 23a) (Type, Print) 1126 Opa1 aseen Durch egistrar's Signatu State DEC Registrar

11-09224 Kennetl Medic ந்த Baltimore, MD 21215-0036 Division of Vital Records, P.O. Box 68760,

h Friend			State of Maryla	nd / Depar	rtment of H	lealth and			201	1.117	
		1- For State Registrar		Cert	ificate of L	Death			g. No.		
Physici al Exam	an/ iner	1. Decedent's Name (First, Kenneth Wayr						2. Date of Death Month December	Day Year 8, 2011	3. Time of Death 0745 hrs	
		4a. Facility Name (if not ins RDute 495 - 1/2 m	ititution, give street and num nile north of Dry Run			City, Town, or L Swanton	ocation of Dea	th	4c. County of Dea	ath	
Funeral		5. Social Security Number	6. Sex 7	⁷ . Age (In yrs. las		If Under 1 Year			(MM/DD/YYYY) 9. E	eian	
Director		216-74-2053	1 X M 2 F		52 _{Yrs.}	Months Days	Hours Mi	Oct. 1	, 1959	Country) Maryland	
any		Usual Residence of Deceder 10a. State 10b. Co		10c. City, T	own or Location					10d. Inside City Limits	
. ■	ō	MD Gar	rrett	Sw	anton					1 Yes 2 X No	
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient Department of Health and Mental Hygient Air and it is a second insportant. If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once,	Director	10e. Street and Number 6872 Bitting	Tor Pd			0f. Zip Code 21561		10	g. Citizen of What Co USA	ountry?	
with th	ral D	11. Marital Status		dent Ever in U.S			anic Origin? (Specify Yes or No-		erican Indian, Black,	
death r item nust b	Funeral	1 Never Married 2	X Married Armed For	ces?		specify Cuban,		to Rican, etc.)	White, etc.	• •	
ral",	Ą	3 Widowed 4	Divorced If Yes, Give Year or Dates:			es 2 X No		Consult dans		nite	
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ithin 7 sne. r than fedica	Completed	12		1	Mason				Construc	tion	
filed w Hygie d othe		17. Father's Name (First, Mi Daniel Levi	, ,					ne (First, Middle, M uth Timme			
uld be Menta marke c even	To Be	19a. Informant's Name/Rela			19b. Mailing A				per, City or Town, Sta	ite, Zip Code)	
d 2 sho Ith and n 27 is	_	Lucinda M. E	riend/Wife					Swanton,			
es lan of Hea If iter iher tra		20a. Method of Disposition 1 X Burial 2 Crem	nation 3 Removal from	n State cre	ace of Disposition	place)		Date	20c. Location - City		
it. Pag rtment ortant: y or of		4 Donation 5 Other		Gle	ndale Ce	-			ll Swantor eral Home		
perm Depa Impo		A XXXXXX	uman					ntsville,			
ysician Medical		23a. Part I. Enter the diseas failure. List only one c		used the death. [Do not enter the	mode of dying, s	uch as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and	
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	_	Sequentially list conditions, b									
	nine	if any, leading to immediate cause. Enter Underlying Ca	ause	consequence of):							
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oe executed ician and inial - transit	dical	UNPENDED	AMENDED								
ficate be g physici s the buri	an/Me	IF FEMALE: 23b. Was decedent pregnan		utcome of pregna		death 3	Ectopic pregr	nancy	23d. Date of deliver	Day Year	
eath certific attending for use as t	- 13 I	past 12 months?	4 Pregna	nt at time of deat	h - H	(Specify)					
t the dea by the a	Physi	Part II. Other significant co	9 Oliknov	vn death but not res	ulting in the und	erlying cause giv	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?	
ceding Physician: The law requires that the death certificate be art. After this certificate has been signed by the attending physici the funeral director, page 2 should be detached for use as the burille.	d b							1 Yes	2 No 3 Pr	obably 4 Unknown	
law requi has been 2 should	Completed							24a. Was ai autops	y prior to	autopsy findings available completion of cause of	
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ician: The s certificate irector, page	Be	25. Was case referred to me examiner?	Linemitel:	patient 2 E	R/Outpatient 3		of Death (Check		tesidence 6 🗸 Ott	ner: Scone	
ing Physion After this uneral dir	.: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date o	f Injury 2	28b. Time of Inju	_ DDA	- INGIS	28d. Describe ho	ow injury occurred	ier. Scerie	
ttendin leath. tor: A	atior	1 Natural 5 ☐ 2 ✓ Accident	Pending FOUND: Dec 8, 20		FOUND: 0715 hrs	1 Ye	es 2 🗸 No	Pedestrian st	ruck by vehicle		
To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6	Could not be 28e. Place	of Injury - At hom		actory, office bu	ilding, etc.	or Town, Sta	ate)	Rural Route Number, City	
Hospita 4 hour: Funera ely fill		4 Homicide 29a. Certifier 1 Certifyii	ng Physician: To the best	Major Road of my knowledge		I at the time, date	e and place, an				
To the How within 24 h To the Fur completely	Medical	Oncon only	I Examiner: On the basis of and manner sta	examination and			-				
. > F 3	ž	29b. Signature and title of co	ertifier	2-00		29c. License			29d. Date signed (A		
		30. Name and address of pe	New - V	of death (Horn?	(32)	O.C.M	I.C.		December 9, 2		
VA	6	Patricia Arphica-P			-	00 W. Baltim	ore Street,	Baltimore, MD	21223		
	ate	31. Date filed (Montal 2)	(ea) 4 2011 32. Red	istrar's Signature	S. San	Kal		_			

11-09212 Charles Frve Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charles Frye		1- For State Registrar	State of Maryla		artment o rtificate o		nd Menta		teg. No. 20	114117
Physician/ 1. Decedent's Name (First, Middle,Last) Medical Examiner Charles Eugene Frye, Jr. 2. Date of Death Month Day Year December 7, 2011								3. Time of Death 1921 hrs		
		4a. Facility Name (if not institu	4b. City, Town, o			4c. County of De	eath			
Funeral		Western Maryland F 5. Social Security Number		7. Age (In yrs.	last birthday)	Cumberlan		24Hrs. 8. Date of Bi	Allegany rth(MM/DD/YYYY) 9.	Birthplace (State or
Director		219-78-1488	1XM 2F		48 y	Months Day		Min		reignPennsylvani Country)
пу		Usual Residence of Decedent 10a. State 10b. Coun		10c. City	, Town or Loca	ation				10d. Inside City Limits
Maryland 28a-f show any d <u>at once,</u>	ъ	PA Some	erset		ina					1 X Yes 2 No
: Maryla r 28a-f	Director	10e. Street and Number				10f. Zip Code		1	log. Citizen of What C	country?
with the	ral D	157 Chestnut 11. Marital Status		edent Ever in U	.S. 13. W	15424 /as Decedent of Hi	spanic Origin	n? (Specify Yes or No	USA 14. Race - An	nerican Indian, Black,
or item	Funeral		Married Armed For	rces?		Yes, specify Cuba	n, Mexican, P		White, etc	.
ırs after tural",	Š	3 Widowed 4 15. Decedent's Education (S	Divorced If Yes, Give Year or Dates: pecify only highest grade	e completed)	16a, Decede	Yes 2X No		nd of work done	Specify: W	
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-003 d withiu giene. ther th	Completed	12 17. Father's Name (First, Midd	lle, Last)		Truck	Driver	18.Mother's	Name (First, Middle,	Trucking Maiden Surname)	
1215 I be file ental Hy nrked o	Be	Charles E. Fr	_				Delann	na Seiman		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once.	Ţ	19a. Informant's Name/Relation Amanda J. Bows		2				er or Rural Route Nur ${ t Confluence}$	mber, City or Town, St	
re, N s 1 and f Health friem		20a. Method of Disposition 1 X Burial 2 Cremat	ion 3 Removal from		Place of Dispo crematory or o	sition (Name of ce	metery,	Date	20c. Location - City	or Town, State
timo t. Page tment o		4 Donation 5 Other 21. Signature of Funeral Servi	Specify:		sher Gl	ade Ceme	tery D	ec. 11, 20	11 Friend	sville, MD
Bal permi Depa Impo		21. Signature of Furieral Servi)lumou					rantsville		
Physician /Medical		23a. Part I. Enter the disease, failure. List only one cau	se on each line.			76	such as card	diac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disea or condition resulting in death				sease				Death
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Box 6876 e death certificat the attending phy ed for use as the	Physicia	1 Yes 2 No 9 U	Inknown 9 Unknow	nt at time of de vn	eath 5 O	ther (Specify)	_			
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To the How within 24 h To the Funcompletely	Medical	one) 2 ✓ Medical Example 29b Signature and title of certi	taminer: On the basis of and manner sta		nd/or investiga	tion, in my opinion		red at the time, date	and place, and due to	
		PIO	-1200			O.C.			December 9, 2	
	5	30. Name and address of personal Policy Aronica Policy	TV_			000 M/ Dakii	nore Ct	ot Doltimar- 127	21222	
St	コ ate	Patricia Aronica-Poll 31. Date filed (Month) Patrice	/	nt Medical E istrar's Signatu		900 W. Baltir	nore Stree	et, Baltimore, MI	J Z1ZZ3	
Regist	_	EXITED TO	2000		13. 14.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Linda Lou Friend 2. Date of Death 3. Time of Death Physician/ December 9, 201^Y1^a 11:50 AM Medical a. Facility Name (if not institution, give street and number) Town, or Location of Death Bloomington 4c. County of Death **Examiner** Garrett If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Social Security Number 214–42–0498 **Funeral** May 23 1941 Months Days Hours 70 Maryland **Director** 1 M 2XXF Vrc 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director notified MD Bloomington Garrett 28a-f 1 Yes 2 No 10f. Zip Code **21523** 10e. Street and Number 10g. Citizen of What Country? United States 9 ritems 23a or ner must be r Funeral PO Box 84, 103 North Hamil Ave. "natural", or iter ledical Examiner r 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Specify: White If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Housework Homemaker n and Mental Hygien 7 is marked other th raumatic event, the 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ano.

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or traumatic ev. ည Clifton Boal Elsie Dawson 19a. Informant's Name/Relationship (Type, Print)
Richard Friend/ husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 84, 103 N. Hamil Ave, Bloomington, MD 21523 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth cemetery, crematory or other place)

Laurel Hill Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 12-12-11 Barton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MUCH HUIS Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Gause (Disease or injury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 pronths?

1 Yes 2 No for 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Id be detached for nderlying cause given in Part I. Part II. Other significant conditions contributing to death but not less 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe has 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Marse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and ad 4th. ST. Oakland MD, 21550 Goralski 3/1 1 2 2011 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Wilma Carletta Fellers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day)
April 15 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** Months 1 🗆 M 2 🗶 F 1947 Mary land 64 218-50-4594 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location items 23a or 28a-f shorer must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 💢 No MD Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21782 17476 Millers Sawmill Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11. Marital Status Medical Examiner Armed Forces? Black, White, etc. ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give White "natural" Completed 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housewi fe Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Jeanette Carletta Ingram Charles Harry Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Hillcrest Drive - Kearneysville, WV 25438 Dessa McDonald - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mountain View Cem. 12/13/2011 Sharpsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eackles-Spencer & Norton Funeral 21. Signature of Funeral Service Licensee M00970 Home - Harpers Ferry, WV 25425 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last To Be Completed by Physician/Medical D Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death ned by the a e detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Disease Rena(Stage 2 No 3 Probably 4 Unknown Hemo dia Lysis 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I perform 2 **N**0 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural Natural Accident 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0069606 December, 10,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD КОДИАН

State

State Registrar

DHMH 17 Rev 7/2009

Antietam St., #306, Hagerstown, ms 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 23a per med cert G922 12/29/11 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard Sutherland Gary 33 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WM Regional Medical Center mber nd 8. Date of Birth (Month, Day, Year Nov. 23, If Unde 5. Social Security Number If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year) Min. Months Hours 1935 Maryland 216-32-4337 76 Director 1 🛛 M 2 🗆 F Yrs Usual Residence of Deced 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State death with the Maryland ms 23a or 28a-f sho must be notified at Director Garrett Swanton MD 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21561 Funeral 2023 Savage River Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iten edical Examiner r Armed Forces? Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 filed within 72 hours after Specify: white 1 ☐ Yes 2 😾 No Specify: Korean 3 Divorced 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Madrio 00000. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Book Writing Writer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Loretta Sutherland ၉ Samuel Thomas Gary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2023 Savage River Road, Swanton, Maryland 21561 Patrick Gary/ brother 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory 12/11/2011 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between SEPTIC Immediate Cause (Final SHOCK 24 Hours Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 4 days Systemic Candidiasis Sequentially list conditions, Examine Due to for as a consequence of if any leading to immediate cause. Enter Underlying burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William Lamm, 12500 Willowbrook Road, Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 1 2 2011

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) De C Dav Physician/ Sibbon Sa Sharan 201 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner ston talbot Moria curity Number 78-52 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** Min. Months Hours Director 965 New Jersel 10d. Inside City Limits items 23a or 28a-f show 10c. City, Town or Location Examiner must be notified at **Funeral Director** 1 Yes 2 No 10g. Citizen of What Country? death with the USA nden Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ō by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Yes 1 Yes 2 P No Specify: If Yes, Give Year or Dates Black "natural", 3 Divorced 4 Divorced Completed other traumatic event, the Medical 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hamportant: If item 27 is many injury or other. 18. Mother's Name (First, Middle, Majden Surname) 17. Father's Name (First, Middle, Last) ဂ hompson John Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number Nicole oleman 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Mt. Pleasant Cemete leasant Cometery 22. Name and Address of Facility
Henry Funeral Home, P. A.
Henry Funeral Home, St. Cambrid
S10 Washington St. Cambrid 21. Signature of Funeral Service Licenses MD,21613 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 1 Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျ filled in by the funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending Investigation
6 Could not be Accident Suicide within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Li 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December Physician/ 2011 15:57 ^M William Gilbertson Medical 4c. County of Death a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Montgomery General Hospital 01ney Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours (Month, Day, Year) Months 556-50-4595 72 Director 1 🛛 M 2 🗆 F Yrs Nov. 26 1939 Iowa Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State Director 1 Yes 2 No Brookeville MD Montgomery 10g. Citizen of What Country? 10e, Street and Number items 23a or ner must be n ō United States Funeral 20833 2936 Dubarry Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?
1

Yes 2 □ No Black, White, etc. 1960 1 Never Married 2 X Married "natural", or ò Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify. If Yes, Give Specify: White 1961 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) U.S. Government Pharmacist other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H Important: If then 27 is marked oth any injury or other traumatic 17. Father's Name (First, Middle, Last) Holder Edna E11sworth Gilbertson William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2936 Dubarry Lane, Brookeville, MD 20833 Barbara L. Gilbertson/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/6/2011 Alexandria, Virginia Metropolitan Crem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Muriel H. Barber Funeral Home Signature of Fune all Service Livens P. O. Box 5038, Laytonsville, Maryland d 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Acute Coronary Insufficiency Physician/ 5 minutes disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 10 minutes Cardiac Dysrhythmia Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Other (specify) the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 1 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d, Describe how injury occurred 27. Manner of Death Certificate: iniury 1 🗹 Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🖂 29d. Date signed (Month, Day, Year, 29c. License number 29b. Signature and title of certifier December 6, 2011 D 47682

State Registrar

Redistrar's Signature

2901 Olney-Sandy Spring Rd., Olney, MD

20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bennett Morrison, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0425 M Physician/ Иe 201 sreen 0 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deatl **Examiner** Talbot Easton Hospita Memorial 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** Min. Months Hours **Director** 1 M 2 - F 5 land items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location at 10a. State Director Examiner must be notified 1 🗌 Yes 2 🗌 No talbot ston 10f. Zip Code 10g. Citizen of What Country? Funeral 2 nion Vi Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Someone injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number or Rural Ro, te Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health Important: If item 27 cille 20c. Location - Oth or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Home, P. 22 Name and Add any Henr Washington Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to for as a consequence of physician and s the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as 1 attending IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year Other (specify) Pregnant at time of death signed by the at Id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform 1 ☐ Yes 2 ☐ No certificate 1 Yes Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 Yes ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending iniury 1 Yes 2 🗌 No Investigation Accident filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and gertifie 4465676 poleted cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 31. Date filed (Month State Registrar

ames

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 30 Month Physician/ 8:40AMM 2011 Thomas Leroy Green Novembe Medical c. County of Death
St. Mary's 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charlotte Hall Charlotte Hall Veterans Home 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number **Funeral** 1 ☑ M 2 □ I Months Days Hours 02/22/1923 Memphis, Director 88 Tenn Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1x Yes 2 No MD Charles Pomfret 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 9550 Hickory Acres Ct. 20675 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian ed Force Black, White, etc. X Yes 2 🗌 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Communications 12 Electrical Engineer Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Loretta Ward Thomas L. Green Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9550 Hickory Acres Ct. Pomfret, MD 20675 Thomas Green 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory Dec. 5,2011 Waldorf, MD permit. 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Licenses MOUGO 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the a 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has the irector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? funivral director, 26. Place of Deat (Check only one) Be Hospital: 2 No ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Affer work? injury Natural 5 Pending 2 No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed ca 764

8

31. Date filed (Month, Day, Year,

ause of death (Item 23a) (Type,

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G924 2/06/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PERRY DEC. 14^y 2011 SHELTON GORDON 6:04AM Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner NEWBURG** 10990 MT. VICTORIA ROAD CHARLES If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 577-01-3607 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min 10-3607 1 🗆 M 2**XX Director** NOV.20,1917 VIRGINIA 94 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f VA NORTHUMBERLAND 1 🗌 Yes 2 🔀 No HEATHSVILLE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 127 CREEK LANE 22743 U. S. A. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. within 72 hours after 1 ☐ Yes 2xxNo Specify Specify: "natural" Completed **¾**Widowed 4 □ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the HOMEMAKER AT HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental F 27 is marked of r traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ည OLIVER PERRY SHELTON KATE MAUDE HINMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MERYLE WILKERSON/DAUGHTER 10990 MT. VICTORIA RD., NEWBURG, MD 20664 20a. Method of Disposition 20b. Place of Disposition (Name of DECEMBER | 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHRIST CH. CEM. 20,2011 IRVINGTON, VA 4 ☐ Donation 5 ☐ Other (Specify) tyre of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 22. Name and Address of Facility RAYMOND FUNL. M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCER OF PANCREAS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner METS. TO LIVER Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown that the death Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? this certificate Yes 2x No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🙀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) DAUGHTER 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at work? 28d. Describe how injury occurred RESIDENCE 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatore and title of certific 29c. License number 29d. Date signed (Month, Day, Year) Shr D20629 d addre who completed cause of death (Item 23a) (Type, Print) WATHEN, M.D., WALDORF, MARYLAND 20603 Η. 31. Date filed (Month, Day, Year) **DEC 2 1** 2011 32. Registra s Signature State Registrar

Maryland 21215-0036

Baltimore,

68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 6:40 AM Mildred Pauline HESS 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 399 Key Circle Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Dec. | 21 Social Security Numbe 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Maryland 1910 **Director** 100 Dec. 214-74-1841 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director be notified 1 X Yes 2 ☐ No <u>Maryland</u> Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 399 Key Circle 21740 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates and 2 shourd...

Health and Mental Hygiene.

Item 27 is marked other than "natur.

Item 27 is marked other than "natur. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Albert Clinton Leedy Lettie Pittinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. If item 27 or other to Doris L. Smith - Daughter 399 Key Circle, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 12/12/2011 Hagerstown, Maryland nature of Funeral Service Licen 2. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) cute renal Medical Due to (ras a consequence of): **Examiner** Sequentially list conditions, if any, localing to immediate cause. Enter Underlying Cause (Disease or iinjury pronic 20 Exam Due to (or as a consequence of): the burial-tran that initiated events resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death the detached q 🗌 Unknown þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No cate has been signated by page 2 should b Completed tractures 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate becompleted filled in by the funeral director, page Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 29b. Signature and title of certifier

Strange

M.O

MD

DEC 0 8 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13424

29c. License number

Pennsylvania Avenue Svite 101

20047231

29d. Date signed (Month, Day, Year)

Maryland

21742

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Mae Haynes Anna /Medical 4c. County of Death acility Name (If not institution, give street and number) Examiner Haaristo If Under 1 Year Jif Under 24 Hrs. (In yrs. last birthda _1923 **Funeral** Davs 1 M 2 F Hours Months Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a, State s 23a or 28a-f show Hagerstown, 1X Yes 2 No Washington Director 10g, Citizen of What Country? 10e. Street and Number 1183 Luther Drive U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. r than "natural", or items 11. Marital Status white 1 Never Married 2 Married 1 □Yes 2 □Xo Maryland 21215-003 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) truck mfg.co Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. secretary permit. Pages 1 and 2 should be filled with Department of Health and Mental Hyglien Important: If Item 27 is marked other the any Injury or other traumatic event, the once. 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harshman Barbara Charles W. Good ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12111 St. Paul Rd. Clear Spring, MD. 21722 Dale E. Miles son 20c. Location - City or Town, State Baltimorė, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Smithsburg, MD 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State 2011 Smithsburg Crem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 21. Signature of Funeral & ruco Licasee P.O.BOX 310 Clear Spring, MD 21722 23d. Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) alzheemer 54ear Physician /Medical Due to (or 1s a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Live birth 2 Fetal death
Pregnant at time of death Month 5 ☐ Other (specify) ed by the s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 2A No 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 1 Natural 5 ☐ Pending investigation n 24 hours after death.

Re Funeral Director: Af bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide i 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 ho To the Fune completely f (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

of person whill completed cause of Jeath (Item 23a) (Type, Print)

1- Hogestonen 190 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Z Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12 Month Physician/ Glenn Albert Hinebaugh 2011 2:38 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett Deer Park 1090 Boiling Springs Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours 10 14 1937 MD (Country) Director 220-32-3912 1 **X** M 2 □ F 74 Yrs Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10b County 10c. City. Town or Location notified at Director Deer Park MD Garrett 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? must be n Funeral 21550 USA 1090 Boiling Springs Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. injury or other traumatic event, the Medical Examiner Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) coal miner coal and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or con-Minnie E. King Robert Hinebaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1090 Boiling Springs Road, Deer Park, MD 21550 Wanda Hinebaugh-wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Deer Park Cemetery 12/12/2011 Deer Park, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home PA 21. Signature of Juneral Service License 21 N 2nd St, Oakland, MD 21550 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cerebrosascon acciden disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Hypertersion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine cardiovascular diceace thero schenotic Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe page 2 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical To the Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DDA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural Accident 5 Pending work?
1 Yes 2 No Investigation filled in by the Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12/12/201 D30035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald R. Richter 1533 Memorial Drive, Oakland, MD 21550

Registrar

DHMH 17 Rev 06-2011

State

32. Redistrar's Signature

4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Mary Thelma Hoffman 12:20 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastallospice At the Salisbury Dicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Min. Jan. 8 ay, Hours 77 1934 Mary land Director 214-28-8499 Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** must be notified 1 X Yes 2 ☐ No Maryland Wicomico Fruitland Page 1 and 2 should be filed within 72 hours after death with the Mai 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 509 Hayward Avenue 21826 USA items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Examiner Black, White, etc. 27 is marked other than "natural", or i traumatic event, the Medical Examin Completed by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 William Byrd Hitchens Bessie Mae Ouillen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 27 3644 Pocomoke Road, Salisbury, Maryland 21804 Terry Lee Graves/Daughter item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important; If it any injury or o once. ŏ X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation Shad Point Cemetery 5 Other (Specify) 12/10/2011 Salisbury, Maryland 21. Signature of uneral Service Lines Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final disease or condition HROMIC Physician/ OBSTRUCTIVA MIMONARY DISPASE Medical resulting in death) Due to (or as a consequence of) Examiner MASS MNa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) as the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death
4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes No
9 Unknown Por Month Day Year ned by the at P.O. sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? certificate 1 🗌 Yes 24 hours after deau... 3 Funeral Director: After this certified lated filled in by the funeral director, ! To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence Other (Specify) HOSPIGE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou

To the Fune

completed file (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 SAZYBURY PO 21802 WARG 733

Registrar DHMH 17 Rev 7/2009

State

Helysy

DEC 07 2011

31. Date filed (Month, Day, Year)

A000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MODEMBERDAY 2011 9:06A FLORA HARSHMAN MARIE Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL FREDERICK MEMORIAL FREDERICK FREDERICK 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Age (In yrs. last birthday, **Funeral** Hours Month, Pay, 3/24/ Country) 1 M 2 X F 84 Director 214-30-2002 Usual Residence of Decedent 10d Inside City Limits 28a-f shov 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director Frederick Frederick 1 X Yes 2 □ No MD 10f, Zip Code 10g. Citizen of What Country? 5 10e Street and Number Funeral items 23a 21701 USA 213 Wyngate Dr. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S 11. Marital Status Armed Force ь Completed by 1 Never Married 2 K Married Yes 2 XNo Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", 3 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) public schools worker cafeteria Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 2 Letha Grossnickle Russell P. Wiles Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $213~{
m Wyngate}~{
m Dr.}$, ${
m Frederick}$, ${
m MD}~21701$ 19a. Informant's Name/Relationship (Type, Print) Harold Harshman (Husband) 20c. Location - City or Town, State 20a. Method of Disposition 20 Glace of Disposition Ampre of Church 1 → Bural 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) of Brethren Cemetery12/9/11 Myersville, grature Donald B. Thompson Funeral Home POB 18 Middletown MD 21769 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Orset and Death shock Immediate Cause (Final sculo Occhusin Physician/ Cerbous disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of): the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year for Pregnant at time of death 5 Other (specify) the 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed? 1 Yes 2 No 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မြ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work?
1 Yes 2 No iniury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Descrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Wedical Examiner: On the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the suggestion of the basis of examination allowed in the suggestion of the basis of examination allowed in the suggestion of the suggestion of the basis of examination allowed in the suggestion of the sugge only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 51610 12 6 olive $\mathcal{Q}\mathcal{M}$

State Registrar

8

Michael

31. Date filed (Month, Day, Year)

Taney

Ave # 201

Frederick, mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1475

32. Registrar's Signature

A Tolino

0

Please Type or Print in Black Indelible Ink-Ensure All Copies Are Legible.

Amend 25 per med cert G923 1/12/12/12/12/12

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Howard F. Hardaway 2011 15:15 Dec. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Number 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Year) 01/24/1924 224 26 8457 87 Director 1 🕱 M 2 🗆 F Usual Residence of Decedent 28a-f show 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location with the Maryland Director Adelphi 1X Yes 2 ☐ No Prince George' MD 10e. Street and Number 10f. Zip Code 10g. Citiz USA Citizen of What Country? Funeral 20783 8402 Rambler Drive death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ŏ 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 within 72 hours after Specify: Black 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Government English Teacher 4+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental his marked o မ Love Hopson traumatic James Hardaway .. Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5069 Everett Rd. Forest, VA 24551 Willie H. Neal/ Nephew other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once, 12/8/2011 Laurel, MD National Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Briscoe-Tonic Funeral Home mberly Old Washington Rd. Waldorf, 2294 MD20601 23a. Parf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician neumoni disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PSI Sequentially list conditions, if any, leading to immediate cause E to Underlying Cause (Disease or injury that initiated events southing industry). Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death be detached the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 thknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate It 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 🗆 Yes Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 68040 6/2011 seen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Takoma Sharma Carroll 31. Date filed (Month. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Eula J. Horsman December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town. or Location of Death 4c. County of Death Examiner charles La If Under 1 Year If Unde 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 1926 Virginia May Director 1 🗆 M 2 🗶 F 85 10d. Inside City Limits 28a-f shov ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State 10b County 10c. City, Town or Location **Funeral Director** 1X Yes 2 ☐ No MD. Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **United States** 20601 4747 Leonardtown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 ▼ Widowed 4 □ Divorced Maryland 21215-00 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Self Employed Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. College (1-4 or 5+) Elementan/Secondary (0-12) Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Lillian Clarke C. Stuart Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17635 Mohr Oak Lane, Hughesville, MD. 20637 Susan Hummer (Daughter) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place Waldorf, MD. Trinity Memorial Dec 9,2011 4 ☐ Donation 5 ☐ Other (Specify) 3035 Old Washington Road 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Waldorf, MD. 20601 |Huntt Funeral Home m0190 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myocardial in farction Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 X ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 5 Pending work?
1 Yes Natural 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier FM2007 513 MALPANTAY MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) garrett Ave La Plata maggantay MD Napoleon 31. Date filed (Month, Day, Year)
DEC 0 8 2011 . Registrar's Signat Registrar

11-09332 Donald Robert Houl	_	pe or Print i tate of Maryl							.egible.	201	1 4119
	1- For State Registrar		Ce	rtificate o	f Death				Reg. No.	201	1 7112
Physician/ Medical Examiner	1. Decedent's Name (First, Midd Donald R. Hou	le, Sr.							Day Der 11, 20		3. Time of Death 1430 hrs
	4a. Facility Name (if not institution Laurel Regional Hosp		umber)		4b. City, Tov Laurel	wn, or Lo	ocation of Deat	th		County of Dec ince Geor	
Funeral Director	5. Social Security Number 006-46-9712	6. Sex	7. Age (In yrs. I	last birthday) 64 Yrs	If Under Months	1 Year Days				(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Mair	
/any	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion						10d. Inside City Limits
ith the Maryland 23s or 28s-f show notified at once.	Maryland Princ 10e. Street and Number			sville	10f. Zip C	ode			10g. Citize	en of What Co	1 Yes 2 No
ith the M 23a or 2 notified	3909 Lakehouse Lighthous	e Road, #3	16		2	0705	5		Uni	ted St	tates
death w	11. Marital Status 1 Never Married 2 X N	Armed F	2 No		es, specify (Cuban, N	nic Origin? (S fexican, Puert		No- 14	4. Race - Ame White, etc.	erican Indian, Black,
urs afte tural", miner	3 Widowed 4 Div	vorced If Yas, Give Ye or Dates: ecify only highest gra		1 16a, Deceden		No s		work done		pecify: What had of Busines	nite
15-0036 I Hygies within 72 hours after death with the Maryland I Hygies of the statural", or items 23a or 28a-f she other than "natural", or items 23a or 28a-f she to Medical Examiner must be notified at once Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+		ost of workir		O NOT use re				ınications
215-0 be filed w ntal Hygic rked othe ent, the N	17. Father's Name (First, Middle Rosario Robert			•			Mother's Nam Rosiann	. ,			
MD 21215-0036 at 2 should be filed within 7 lith and Mental Hygiene an azir e went, et dether than an azir e went, et dether than To Be Compile	19a. Informant's Name/Relations Rosmarie Houle			19b. Mailing	Address Lakel	(Street a	nd Number or	Rural Route N	lumber, City	or Town, Sta	te, Zip Code) 1D 20705
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after a popuration of Health and Mental Hygene Important: Witem 21 is marked other than "natural", injury or other traumatic event, the Medical Examinet. To Be Completed by F	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other S	n 3 Removal fr	rom State	Place of Dispos crematory or oth	ition (Name ner place)	of cemet	tery,	Date 12/2011	20c. Lo	cation - City o	or Town, State Virginia
Balti permit. Departm Imports injury o	21. Signature of Funeral Service		dil-	Bol ///		dores	rgward Mill D	t Fune	ral H	Home, H	PA aryland20705
Physician /Medical	23a. Part I. Enter the disease, or failure. List only one cause	complications that o	aused the death.	. Do not enter th	ne mode of o	der dying, su	ch as cardiac	or respiratory	arrest, shock	, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)		rotic Cardiov		ease		_				Death
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of	f):							
executed an and al - transit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of								
8 g g S	UNPENDED	X AMENDED			H g923	3 1/	18/2012	Jh			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unit	1 Live b	ant at time of de	2 Fet	tal death ner (Specify		Ectopic pregna	ancy		Date of delive onth	ny Day Year
P.O. Be sthat the degreed by the by Phy	Part II. Other significant condit	ions contributing to	own o death but not re	esulting in the u	nderlying ca	use give	n in Part I.				o the cause of death?
rds, P	Bronchitis/Pneumonia	a			·			24a. Wa			utopsy findings available completion of cause of
tal Records, leian: The law requires certificate has been sigector, page 2 should be Be Completed	25. Was case referred to medica				26.1	Place of	Death (Check	per 1 Y Yes	formed?	death?	
f Vital Physician er this cert ral directo	examiner? 1 ✓ Yes 2 No	Hospital:	npatient 2	ER/Outpatient		Oth	05.	ng Home 5	Residence	e 6 Othe	er:
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. **In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by Perification:	27. Manner of Death 1 Natural 5 Pend	28a. Date (Month stigation	of Injury , Day,Year)	28b. Time of In	njury 28c	. Injury a	t Work?	28d. Describ	e how injury	occurred	
Division of spital or Attending looms after death. meral Director: After filled in by the funce.	3 Suicide 6 Could deter		e of Injury - At ho	ome, farm, stree	t, factory, of	fice build	ling, etc.	28f. Location or Town,		Number or R	ural Route Number, City
To the Hos within 24 h To the Fun completely		nysician: To the bes miner: On the basis of and manner si	of examination ar								
W SHOW	29b. Signature and title of certifie					cense nu				te signed (Mi	onth, Day, Year)
Mr. Bur	30. Name and address of person Ana Rubio MD. Ass	who completed caus			more Stre	eet. Ba	ltimore Mr	D 21223			<u> </u>
State	31. Date filed (Month, Day, Year)		gistrays Signate			,					-

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DOC Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Dorchester General Hospital ambrida ster Year If Under 24 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) 68 **Director** 1 🛛 M 2 🗆 F Maryland or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral Fairmount Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1964 If Yes, Give Year or Dates. 1968 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 I Hygiene. other than "natural", 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Jack 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electric Company cal neman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental I item 27 is marked o 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD: 2/6/3 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State Maryland Hurlock, 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Henry Funeral
SIO Washir MD.21613 washington Str Cambridg 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEART STAGE DISEASE Physician/ KND Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the buris Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 1 ∐ Yes 2 L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 1 L Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 **10** No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Afcompletely filled in by the fu 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 69234 MD 02 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21613 JEEVAN ERRABOLU 503 BYRN STREET CAMBRIDGE 31. Date filed (Month, Day, Year, State NFC 08 2011 Registrar

11-09175

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arl Edward Jack		1- For State	tate of Maryla		epartment d Certificate d			Menta	l Hygiene	Reg. No.	20		4119
Physicia Medical Examin	n/	Registrar 1. Decedent's Name (First, Midd Carl Edwar		on.					2. Date of D Month	eath Day	Year	3	Time of Death
viedicai Examin	er	4a. Facility Name (if not institution				4b. City, T	own, or L	ocation of D	Decemb		011 c. County of De	eath	2100 1113
		Travellers Rest Road				Camb	oridge			[Dorchester		
Funeral		5. Social Security Number	6. S ex		yrs. last birthday)	If Unde	er 1 Year s Days	If Under 2 Hours	Adin		/DD/YYYY) 9. Fo	reign	
Director		217-42-5326	1X M 2 F	68	Yı				Sept.	5,	1943	Coun	tv)Maryland
, ģ	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Loca	ation						1	Od. Inside City Limits
E no	اڃ	MD Doro	chester				Cambi	ridge				1	Yes 2 X No
Maryland Assert show	Director	10e. Street and Number	1 D .			10f. Zip	Code	0171	0	10g. Citi	izen of What C		P
th the Maryland 23a or 28a-f sho anotified at once		5313 Backwood						2161			USA		
ath wi	Funeral	11. Marital Status1 Never Married 2 X M		orces?	If				(Specify Yes or I lerto Rican, etc.)	No-	14. Race - Ar White, etc	c .	n Indian, Black,
fter de		3 Widowed 4 Div	1 Yes /orced if Yes, Give Yes or Dates:		No 1	Yes 2	X No	specify:			Specify:	wh	ite
nours a	6 8	15. Decedent's Education (Spe	cify only highest gra					n (Give kind	d of work done	16b. l	Kind of Busine	ss/Ind	ustry
136 hin 72 hours af e. than "natural tedical Examin	Bet	Elementary/Secondary (0-12)	College (1-4 or 5+)		ntena	•		,	wi	re fab	ric	mfg.
5-0036 led within 72 hours afte tygienie. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle	, Last)				18	3.Mother's N	lame (First, Middle	, Maiden	Surname)		
21215-0036 ould be filed within 7 Mental Hygiene, 1 marked other than ic event, the Medica	å	Harry Jackso							an Simps				
_ 2 0 9 2 1	٩	19a. Informant's Name/Relations Barbara Jacks		wife		-	,		or Rural Route N		•	tate, Z 613	
Ore, MD ges I and 2 sh of Health an if item 27 i	ŀ	20a. Method of Disposition			20b. Place of Dispo	sition (Nan	ne of ceme		Date		Location - City	or To	wn, State
Baltimore, permit. Pages 1 ar Department of He Important: If ite injury or other tr	-	1 X Burial 2 Cremation 4 Donation 5 Other S		rom State D	crematory or o Orcheste			rk	12/9/11	Ca	mbridg	e.	MD
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Physician /Medical		failure. List only one cause	on each line.		oddi. Do not onto		, u jg, o.	aon ao bara		, , , , , , , , ,	3, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,		Between Onset and Death
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nted d ansit		events resulting in death) Last	Due to (or as a	a consequen	ice or):								
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x 68 h certif tending use as	<u> </u>	past 12 months?	4 Pregr	nant at time	of doath	etal death other (S <i>pe</i> c	3 ∟ cify)	_Ectopic pr	egnancy		Month	Day	Year
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visior or Attend fter death birector: in by the	ertification:		stigation Dec 5, 2 ld not be 28e. Place		2000 hrs At home, farm, stre	et, factory	office bui	ilding, etc.	28f. Location		and Number or	Rural	Route Number, City
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	t	30. Name and address of person			. ,) \A/ P=1	limor- (Street De	ltimere MD C	1222			
Sta	fa	Donna M. Vincenti, M 31. Date filed (Month, Day Year)			xaminer 900		urnore S	oreet, Ba	alumore, IVID 2	1223			
Registr		NFC 082	011 Dens	ر س	influre park								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death DECEMber Physician/ 534 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AMBriDG DORCHESTER ENERAL ORCHESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) Funeral Min Country) Director 8040 Usual Residence of Decedent Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1X Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 000 Mon 17 at Sunter 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. <u>ک</u> 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cambridge. Cremitica Centa Signature of Funeral Service Licensee 22. Name and Address of Facility ussan-Branwell Funoral Home Cambridge 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fall Pnysician/ onycative disease or condition r Medical resulting in death) onsequence of): Due to (or as a Examiner ardiomy002 Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Exami Cause (Disease or linjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ¥ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 🛛 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Ducse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 50804 13-2-(1 WD Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

Registrar's Signatu

ByonStreet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 12:10 A.M Arthur E. Krum, Jr. December 1 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick . Social Security Num 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, Hours Director 1 **X** M 2 \square F 579-18-4545 11/05/1922 Usual Residence of Decedent 89 D.C. 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 14217 Chadwick Lane 20853 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ö 3 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. WWII 1 Yes 2 No Specify. 'natural", 3 Widowed 4 Divorced Completed White er than "natur , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) topographer Mapping is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur E. Krum Laura Davenport I and 2 should b f Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur E. Krum, III/son 9308 Oak Spring Ct., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 듄 1 Burial 2 X Cremation 3 Removal from State injury or Department o Important: If any injury or once, 12/07/2011 Frederick, MD 4 Donation 5 Other (Specify) Stauffer Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityStauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the diselve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fall and List only one cause on each line. Approximate Interval Between Onset and Death WSOFFICIMICS Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of): -purialphysician the burial Physician/Medical Box 68760 been signed by the attending should be detached for use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 🗌 Yeş 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform ☐ Yes 2☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 L Other (Specify) Hospice ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After To the Hospital or Attending Natural 5 Pending injury Accident Investigation completely filled in by the Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 44 18111 Prince Philip Dr., Olney, MD 20832 gistrar's Sig State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBEL 5 2011 Vickie Kelly L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AHNE CHEN trimage Washineton Meailal If Under 8. Date of Birth 9. Birthplace (State or Foreig Age (In yrs. last birthday)

57 Yrs. Funeral 07-26-1954 1 □ M 2 🎗 F Months Days Hours Min North Carolina 577-74-4754 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10b. County 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🛚 Yes 2 🗌 No Capitol Heights MD PG 10f. Zip Code 10g. Citizen of What Country? USA 10e. Street and Number 20743 Funeral 1302 Nye St. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Completed by timore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify: and Mental Hygiene. 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) New York City Public College (1-4 or 5+) Elementary/Seconday (0-12) Occupational Therapist Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dumas Rosa ည Kelly Isaac 19a. Informant's Name/Relationship (Type, Print) Kathy Tyndell/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 11338 Drumsheugh Ln. Upper Marlboro, MD 20774 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State Harmony Memorial Pk 12-12-2011 Landover, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH Signature of Funeral Service Licen Manalde 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final .Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ____ Month Year Day Pregnant at time of death 4 ☐ Pregnant a 1 ☐ Yes ∠ 2 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown ivision of Vital Records, Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 \ No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation Accident 24 hours after death Funeral Director: 6 Could not be within 24 hours after dearmost To the Funeral Director completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Stanature Name and address of person who complete cause of death (Item 23a) (Type, Print)

ABAID 301 Hospital and Cien Burne State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	e of Ma	aryland		irtment			ind Me	ental Hy	giene Reg. No.	/ 11		41198
	B		1. Decedent's Name (Fir	rst, Middle,	Last)		-	-		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		- 1	2. Date of De Month	ath Day	· ·	ear ;	3. Time of Death
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	/Medical Examiner		resulting in death)		Du	e to (or as	a conseque	ence of):									`
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Records,	law requires that the as been signed by th 2 should be detache	Completed											24a. Was		24b. W	ere autops	y findings available
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	ospita hours ineral y filler	aic	29a. Certifier	Certifying	p Physician: T	o the best	of my know	ledge, death	occurred	at the tim	ne, date and	d place, a	nd due to the	cause(s)	and man	ner as stat	ed.
	To the Hospital or Mithin 24 hours after or To the Funeral Direct completely filled in by	edicai	(Check only 2 one)	Medical	xaminer: On t and	manner st	ated.	on and/or in	vestigation,	, in my of	oinion, deat	th occurre	d at the time.	, date and	place, ar	nd due to ti	ne cause(s)
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	OPVI	18	30. Name and address of	of person v	who completed	caused d	death (Item :	23a) (Type,	Print)	7	. 1-	1+12	arrel	Dear	4	2174	10
1	Sta	te.	31. Date filed (Month, D	ay, Year)	V:	32. Registi	rar's Signatu	ore /	ice o	1116	u	116	1			<u> </u>	
	Registr	ar .	29b. Signature and title JULI 30. Name and address of ANZA 31. Date filed (Month, ODEC)	z 1 20	111 Se	upu	A.	grant	The same of the sa								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helen Irene Lewis Month 2 Day 10:05p ^M 2011Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Dennett Road Manor, Inc. Garrett Oakland If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours **Director** 214-92-7777 1 M 2 X F 92 05 07 1919 WV Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Garrett 0akland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4389 Kempton Road 21550 USA 1. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian. Examiner Black, White, etc. Armed Force 5 þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 nan "natural", o Medical Exan 1 ☐ Yes 2 X No Specify If Yes, Give Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, than Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home other t Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ည Verlinda Arnold James Lipscomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Rosemary Steadman-daughter 122 Wayne Harvey Road, Oakland, MD 21550 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o ō 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/16/2011 Fairview Cemetery Oakland, MD 22. Name and Address of Facility David A. Furdock Funeral Home, P.A. Funeral Service Licensee 21 N. 2nd St, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Alzheimers eave Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as attending use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 Fetal death ò Month Day Year Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in 24 hours after deam.
In 24 hours after deam.
The Funeral Director; After the 27. Manna of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending work 2 No 1 🔲 Yes М Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) e of certifie 29b. Signature a 29c. License number H26154 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Daniel Miller, D. O., 69 Wolf Acres Drive, Oakland, MD 21550 31. Date filed (Month, Day, Year)

State

Registrar

32. Registrar's Signature

DEC 16 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 10, 2011 Edna Roberta Livengood 2:50 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Garrett Goodwill Mennonite Home Grantsville 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F 052-20-2275 Oct. 14, Year 1917 Maryland 94 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Friendsville 1 X Yes 2 No Garrett MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21531 USA 244 Maple St. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces þ Black, White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Garrett Co. Community Elementary/Seconday (0-12) College (1-4 or 5+) Action Comm. Case Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Lula Belle Hoover William Edward Swauger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21531 52 Milton DeWitt Rd., Box 175, Friendsville, MD David W. Livengood/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Blooming Rose Cemetery Dec. 15, 2011 Friendsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, F.A. Signature of Funeral Service P.O. Box 275, Grantsville, MD 0 23a. Part 1. Enter the shock, or heart disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a son sequence of: -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IE FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been signated by page 2 should b Completed 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 (No Yes 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury 1 Yes 2 No after death Director: Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) December 12, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Monti

21536

Robin Bissell, 124 Miller St., Grantsville, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** December 8 2011 Mary LeCompte Lawrence /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cambridge DORCHESI GENERAL HU30, tAL DORCHESTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 28, 1918 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 💆 F Maryland 083-36-4865 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examiner must be notified at 1 X Yes 2 No Director Maryland | Dorchester East New Market 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21631 6 Railroad Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Saltimore, Maryland 21215-0036 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐Yes 2 No Specify. White 3 X Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Registered Nurse h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Rebecca Willis Samuel Jones Tilden Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health at Important: If Item 27 Is 1 any injury or any injury o Rebecca Enochs/Daughter 105 S. Winterberry Court, Smithfield, VA 23430 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/11/2011 | East New Market, MD East New Market Cem. 22 Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 21. Signatur of Funeral Service Ligen Approximate Interval Between Onset and Death Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cordio refreky Immediate Cause (Final disease or condition resulting in death) a well-**Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Conditivateurer seno alertic be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown icate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 ☑ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 — **certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 — **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

NOMAN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THANWY

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32. Registrar's Signature

ST CAMBRIDGE MD 2/6/3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death -Westminster rroll Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Year 1 M 2 V F 212 24 Maryland Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1129 W. 21740 U.S.A. Washington St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No "natural", Specify: 3 Divorced 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 l h and Mental Hygiene. 7 is marked other than "n Flementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Unknown Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Helen Hershburger Wilbur L. Andrews permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4105 Winfield Way, Westminster, MD Jack Llewellyn, Jr./Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 12/13/2011 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 21742 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (r as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjuly that initiated events Examine attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 🖎 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

s certificate has t lirector, page 2 s funeral director, Be ၉ this To the Hospital or Attending Physicial Within 24 hours after death.

To the Funeral Director: After the Completed filled in by the funeral Certificate:

25. Was case referred to me

2 🖪 No

examiner? 1 Tes

27. Manner of Death

1 X Natural

__ Accident

Suicide 4 Homicide

						1 ☐ Yes 2 🔼 No	1 ☐ Yes 2 ☐ No							
to medical	2	26. Place of Death (Check only one)												
*No	Hos	spital: 1	ER/Outpatient 3	3 🗆 1	OOA Other: 4 Nursing Ho	Home 5 ☐ Residence 6 ☐ Other (Specify)								
5 Pending Investigation 6 Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury	M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occ	urred							
	e	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street,	facto	ry, office	28f. Location (Street and Nur City or Town, State)	mber or Rural Route Number,							
	- 1													

29a. Certifier	1 Certifying Physician: To the best of my knowledge, death or	ccured at the time, date and place, and due to the	cause(s) and manner as stated.
(Check	2 Medical Examiner: On the basis of examination and/or investig	gation, in my opinion, death occurred at the time, da	te and place, and due to the cause(s) and manner state
only one)	3 Certifying Nurse Practioner: To the best of my knowledge, de	eath occurred at the time, date and place, and due to	the cause(s) and manner as stated.
	nd title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
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Date filed (Month, Day, Year) DEC 13 201

DHMH 17 Rev 7/2009

State

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Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 15 2011 Physician/ RAYMOND K. LLOYD, JR. 2:45 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Kent Kennedyville 13521 Kentmore Park Rd. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Aug. 23 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) **Funeral** Year) 919 1 🙀 M 2 🗆 F 92 Delaware 222-07-4587 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must he notified at 10a. State Director MD Kennedyville 1 Yes 2X No Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21645 U.S.A. 13521 Kentmore Park Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2

No
If Yes, Give

W Black, White, etc Completed by 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WWII 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Transportation Corporate Pilot Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Ann Bratton ျ Raymond K. Lloyd, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 13521 Kentmore Park Rd. Kennedyville, MD. 21645 (wife) Barbara T. Lloyd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 12/20/11 Shrewsbury Cemetery Kennedyville, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech re of Functial envice L M00510 Galena, <u>118 West Cross St</u> Rart .- Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ metastasis Sarcoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Social stally let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): and I-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last been signed by the attending physician sylvened for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year in the past 12 months? Day Month Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been s completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 4 Nursing Home 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d, Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The continuity is a second of the control of the co 0 11/1llum, MD D21313 12/16/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kin Kue Wun, M.D. 415 Washington Ave.

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

2011

32. Registrar's signatur

Chestertown, MD. 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shirley M. December 10, 2011 Lee 1:45P. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Prince George's **Examiner** 4b. City, Town, or Location of Death Adelphi 9706 22nd Avenue . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏋 F Months Days Hours 216-22-3310 Jan:16,1928 Director Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland must be notified at Director 1 🗆 Yes 2 🔀 No 28a-f Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? Funeral 23a United States 20783 9706 22nd Avenue item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married . Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4-or 5+) Elementary/Seconday (0-12) and Mental Hygiene. own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Andrew Murphy Kathleen Goldsmith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Matthew Lee -son 9706 22nd Avenue Adelphi, Maryland 20783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 0 cemetery, crematory or other place 6 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Metropolitan Crematory 12/12/2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Poneld Alless Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) recest Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the ueath or universe or within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical $\mathcal{A}\mathcal{L}\mathcal{A}$ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year Pregnant at time of death 1 | Yes | No 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 🔎 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 Aresidence 6 \square Other (Specify, Hospital: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Jecember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #

State

Registrar

31. Date filed (Month, Day, Year)

2 1 2011

32. Registrar Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ December 201^{ff} Meredith Eleanor Murray 10:55 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maugansville Washington Charlotte's Group Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F (Month, Day, Year) 05/16/1915 Brockton Director 96 011-09-0624 Usual Residence of Decedent 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington MD Maugansville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 13735 Village Mill Drive 21767 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black. White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 N Divorced Sound by the state of the state Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) th Nurse's Assistant <u>Geriatric Care</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of 2 should be George Francis McDevitt Eva Viola Horne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is Jean M. Anders / Daughter 323 Frederick St., Hagerstown, MD 21740 Saltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9 Department Important: If any Injury or Cedar Lawn Memorial Park 12/12/2011 | Hagerstown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home Potomac St. Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ disease or condition Alzheimer's Disease 10 Years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and resulting in death) Last Due to (or as a consequence of) burialphysician certificate be Physician/Medical 68760 the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death in the past 12 months? ō Dav Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown detached P.0. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 No Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 Yes 2 No 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🗶 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 1 Yes 2 🔀 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this and annieted filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

Registrar DHMH 17 Rev 7/2009

State

IW-Z

Herr

Manzar Shafi

Dr. Manzar Sin.
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

368 Mill

egistrar's Signature

D28365

Hagerstown, MD 21740

December 9, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ TRENE TYERS 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death County of Death Julia Manior Health Case Haberstown Jashington 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours July 10,1927 213-24-9187 Maryland Director 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f sho any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21742 USA 20014 Rosebank Way Apt.209 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2XXNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 🛮 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Manufacturing 10 Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fred Leroy Everheart Pauline Elizabeth Corderman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Catherine Palmer - Daughter 111 West Potomac St. Apt.3R Williamsport,MD 21795 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2 X Cremation 3 Removal from State 1
Burial 4 Donation 5 Other (Specify Hagerstown Crematory 12-08-2011 Hagerstown, Maryland 21. Sign fore of Coneral Cerv 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death **Physician** Athero Sclero Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (o) as a consequence of) attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabates Mellitus, Congestive Heart Failure, Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Thronic Obstructive Pulmonary Disease 24a Was an After this certificate has funeral director, page 2: performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) မ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: A

Completed filled in by the 1 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

JW-I

31. Date filed (Month, Day, Year)
DEC 0 9 201

Naderi-

Barbara

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jucher, CRNP 32. Redistrar's Signature

SP-333 Mill Street, Hagerstown, MD 21740

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 15:07pM Physician/ 12-05-2011Medical 4a. Facility Name (if not institution, give street and number) 4b Town, or Location of Death Washington **Examiner** Hagerstown, Meritus Medical Center al Security Number 7. Age (In yrs, last birthday) 8 4 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-22-7866 5-1-1927 Country . 1 □ M 2 □ F Director "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a State filed within 72 hours after death with the Maryland Director Maugansville MD Washington 1 Yes 2 No 10f. Zip Code 21767 10e. Street and Number 14032 Village Mill Drive 10g. Citizen of What Country? U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc by 1 Never Married 2 X Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicall once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) trucking co. Flementary/Secondary (0-12) 10th grade College (1-4 or 5+) driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel L. Hawbaker ည Grover C. Myers Sr. 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code)
14032 Village Mill Dr. Maugansville MD 19a. Informant's Name/Relationship (Type, Print) wife Lena M. Myers 21767 Oc. Location - City or Town, State Hagerstown, 20a. Method of Disposition 20b. Place of Disposition (Name of 12<u>₽</u>9°_ 2011 1 XBurial 2 Cremation 3 Removal from State Mt. Tabor Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fiveral Service Licens Donald Edwin Thompson Funeral Home, Inc P.O. BOX 310 Clear Spring, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause disease the line. Approximate Interval Between Poset and Death Immediate Cause (Final Physician/ matoma disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease Or Injury that initiated events and the burial-tran Due to (or as a consequence of resulting in death) Last month Liver Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ate has been signed by the atter page 2 should be detached for i in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No 9 Unknown 9 🗌 Unknown To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes الاركال Division of Vital Record 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be ြုင် Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1- Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending work? after death. 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of exa ation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) Name and address of p Rd Williamsport State 08 201 Registrar

Amended #5 per funeral Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. director, 12/16/11, vw State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 41208 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12 Month William Day Physician/ John Murphy 2011 Year 13 8:23 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Garrett 109 G St. Mt. Lake Park If Under 1 Year If Under 24 Hrs. Social Security Number 216-38-1436 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min (Month, Day, 09 29 Hours 1940 Director 1 X M 2 D F 71 Washington, DC Usual Residence of Decede show 10b. County 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 28a-f 1 X Yes 2 No Mt. Lake Park MD Garrett 10e. Street and Number 10f. Zip Code Ċ 10g, Citizen of What Country? 23a by Funeral 21550 USA 109 G St nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗷 No 1 Never Married 2 Married 1 Yes Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. 3 Divorced 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) car industry vehicle hauler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Augusta Hardesty James Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 G. St, Mt. Lake Park, MD 21550 Christine Stemple-wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 12/14/2011 Cumberland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home PA surdock N 2nd St, Oakland, MD 21550 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line... Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 5/11(Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) igned by the attending physician be detached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 10 Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending injury Accident Investigation 6 Could not be Suicide

Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, completely filled in by the funeral director, within 2

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

D0061801

12/14/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Buczynski, M.D., 311 North Fourth St, Suite 1, Oakland, MD 21550

State Registrar

Medical

31. Date filed (Month, Day, Year)
DEC 1 6 201 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-09096 State of Maryland / Department of Health and Mental Hygiene Dillon Thomas Moran 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle.Last) 2. Date of Death Physician/ Month Month Day December 3, 2011 0107 hrs Medical Examiner Dillon Thomas Moran 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Davidsonville 3448 Riva Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Maryland Months Days Hours 212-45-2156 Director May 19. 1 X M 2 F 16 Vrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location M 10a State 10b. County 1 Yes 2 V No s 23a or 28a-f show e notified at once. or 28a-f show Davidsonville Maryland Anne Arundel permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21035 USA 3448 Riva Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes White 1 Yes 2 X No specify: Specify: 4 Divorced If Yes, Give Year 3 Widowed 2 or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Education Student 10t.h 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara Ann Carr Martin Shawn Moran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3448 Riva Road, Davidsonville, Maryland 21035 Martin S. Moran/ Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/4/11 Edgewater, Maryland Kalas Crematory 4 Donation 5 Other Specify 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Mudical Death a. Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year 1 Live birth Fetal death past 12 months? 4 Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown <u>ā</u> Completed 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No page 26.Place of Death (Check only one) 25. Was case referred to medical director, examiner? Other Nursing Home 5 Residence 6 🗹 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? After Manner of Death Subject shot self **FOUND** 1 Natural 1 Yes 2 V No after death.

Director: A in by the fu Pending Dec 3, 2011 0100 hrs 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after 1 3 V Suicide Could not be or Town, State) 3448 Riva Road, Davidsonville, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 3, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Donna M. Vincenti, MD 31. Date filed (Month, Day, Year) UEC 0 6 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	f Marylar		artment o			Mental Hy	giene Reg. No. 2	011	41210
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	he Mi	Directo	Maryland Montgom	ery	Bet	hesda	10f. Zip Co	nde			10g. Citize	n of What Cou	untry?
	with Ba or	i	6904 River Road				20817				Unite	d Stat	es
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Baltimore,	Pages nent of h int: If ite		1 ∑ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe							Dec 10 20			, New York
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Division of Vital Records, P.O.	er dearector	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Plac	ce of Injury - At		treet, factory, o	office			(Street and own, State)	Number or Ri	ural Route Number,
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)	2		30. Name and address of person w				, Print)		•				
_	5		Susan J. Miller				n Ave.	Su	ite 305	Bethesd	a, MD	20814	
R	Sta Regist	ate rar	31. Date tiled (Month, Day, Year) DEC 0 8 2011	Bears.	Registrar's Sig	mature -							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 16 Physician/ ANO VIRGINIA MILLER 20T1 1:33 p. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1495 Eastern Boulevard North Hagerstown Washington 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 💢 F Months Country) Maryland 214-10-1096 92 **Director** 1919 November Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ¥ Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a 1609 Langley Drive 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No 1 Never Married 2 Married "natural", or ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Hair Stylist Cosmetology 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fili Department of Health and Mentall Important: If item 27 is marked c any injury or other traumatic eve ၉ Melinda Dorsey Brockley Gilbert Ev a Summers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Stottlemyer / daughter 1495 Eastern Boulevard North, Hagerstown, MD 21740 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Creatation 3 Removal Mt. Zion U. Methodist Dec.20,2011 Myersville, Maryland 4 Donation 5 Other (Specify) 504 Main Street eral Service 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Inter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. PANCREATIC CANCER Approximate Interval Between Onset and Death Physician/ WEEKS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ending physician use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No o Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I \$ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has l 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Kother (Specify) Daughters H 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: After † iniurv 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: After Director or Director. 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D53634 MX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) //// MEDICAL CAMCUS HAGERSTONN

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

32. Registrans Signat

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			_ For	State of Ma	aryland / Dep	artment of I	Health and M	lental Hygie	ne		
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho many injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Black, White,	^{etc.} /hite						
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<u>la</u> n	l be fi fental rked tic ev	잍	James T. He	rshberaer			Anna I	_ee Ellis			
Maryland	should and N is ma		19a. Informant's Name/Relationship (Type, Print)					y or Town, State, Zip		
	and 2 s Health em 27 ther tra		Paul Miller	hu	sband 1	4808 McN	/lullen High	way Cres	aptown	MD 21502	
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other Spec	☐ Removal from State		osition (Name of matory or other place Memorial G	ce)	Date 20 12/16/2011	c. Location - City or To LaVale	own, State	
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Division of Vital Records,	ital or Attendii ins after death. al Director: A led in by the fu	al Certificate:	4 - Homicide determined	building, etc	ry - At home, farm, st . (Specify)	reet, factory, office		City or Town, S	t and Number or Rura tate)	i Houte Number,	
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	11 m		8n	r Mls	mh)))C	54004		12-14	- 2011	
	7 /10		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	Print) TONAL	MIGH	L YAW	AVALE, Y	MD 21502	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1					

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	For State Registrar	First Middle					ertificate of		-	,	Reg. No	201	1 4	121		
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	5. Social Security No. 225–34–	1260	6. Sex	M 2 X F	7. Age (In yrs. 81	last birthday) Yrs,	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da		9. Bi	irthplace (Sta ountry) St Vi	te or Foreigr rgini		
tor	Usual Residence of 10a. State	10b. County			10c, Ci	ty, Town or L								e City Limits		
Director	MD. 10e. Street and Nun		arfo	ord		Jarrettsville 10f. Zip Code						10g. Citizen of What Co				
Funeral	3920	Grimm	_			2				Stat	es					
ρ	11. Marital Status 1 Never Marri 3 Widowed		ried	2. Was Deced Armed Ford 1 Yes If Yes, Give Year or Dat	2X No	S. 13.	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 💢 N	oan, Mexicar	n, Puerto			14. Race - Am Black, Whi Specify:				
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Bec	12. 17. Father's Name (I		.ast)			1 Te	acner's		er's Nam	e (First, Middle,			r Eau	Caul		
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	19a. Informant's Na					\ 1	ling Address (Stree									
	Amy L.		ey_	(Dau	ghter		O Grimm					ville,				
	1 Burial 2	Cremation	3 🗆 Re	emoval from S	State	cemetery, cre	ematory or other pla			Oll		npstea				
	21. Signature of Fur			2	A T		Cremat 22. Name and Addr	ess of Facili	ty E.	G. Ku	rtz	& Son	Fune	ral		
\dashv	23a. Part 1. Enter t					th. Do not er	HOME, F					le, Ma	Approxi	mate		
	shock, or hear Immediate Cause (disease or condition resulting in death)	Final	a.			uence of):	decemila	ı				-		Between nd Death		
Examiner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or	mediate	b.	Due to (c	r as a conseq	uence of):										
ਰ	that initiated events resulting in death) Last C. Due to (or as a consequence of):															
	IF FEMALE: 23b. Was decedent in the past 12, 1 ☐ Yes 2 9 ☐ Unknown	nonths? No	T	1 Live B	ant at time of	al death 3	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					23d. Date of d Month	Year			
	Part II. Other signif	icant condition	ons conti	ributing to de	ath but not re	sulting in the	underlying cause (given in Part	I.			use contribute t		_		
Completed by										24a. Was auto perfo 1 🗆 Yes	psy ormed?	prior to death?	utopsy findir completion	of cause of		
Be C	25. Was case referre	ed to medical					26.	Place of Dea	ith (Checi		<u>الب ع</u>		00 \2 110			
욘	1 Yes 2 2 27, Manner of Death		Ho	spital: 1 🔲 I 28a. Date o	•	ER/Outpati	ent 3 LI DOA					6 Other (Spe	ecify)			
Certificate:	1 Natural 2 Accident 3 Suicide	5 Pendin Investig 6 Could	gation	(Month	n, Day, Year)	injury	M 1 E	ork? ☐ Yes 2 ☐	- 1	28d. Describe						
	4 🗌 Homicide	determ		28e. Place o buildin	of Injury - At h g, etc. <i>(Specif</i>	ome, farm, s	treet, factory, office			28f. Location (City or Tou		nd Number or R e)	ural Route N	umber,		
Medical	(Check 2 only one) 3	☐ Medical E	xaminer Nurse F	r: On the basis	s of examination	on and/or inve	occured at the time estigation, in my oping, death occurred at	nion, death o	ccurred at	t the time, date	and place	e, and due to the	e cause(s) and	I manner stat		
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23d. Date signed (Month, Day, Year)															
	30. Name and addre		who com							BEL AIR			014			
	DAVID DU	h, Day, Year)		_	JEST MA		L MOAD			DEL AIR	, ril	, 410	J17			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ DONALD RAY MILLSAPS, JR. DECEMBE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICH 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral №** M 2 🗆 F Months Days Hours Min. 11-10-1953 CA Country) 212-66-5519 58 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 X No MD. CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral "natural", or items 23a 7185 ANNAPOLIS WOODS ROAD 20646 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 14 Race - American Indian 11. Marital Status Was Decedent Ever III 0.5.
Armed Forces?
1 ☑ Yes 2 ☐ No ARMY
If Yes, Give
Year or Dates. VIETNAM Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE Completed 3 - Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and 2 should be filed within 7: Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PLUMBING CO'S. PLUMBER 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DONALD RAY MILLSAPS, SR. MARIAN SCHROEDLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARBURY, MD. permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troones. DARYL MILLSAPS-SON 4590 BICKNELL RD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MF. cemetery, crematory or other place) METROPOLITAN CREMATORY 12-19-11 Signature of Funeral Service Licenses M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death Unknown 9 Unknown <u>O</u>. signed by t 23e. Did tobacco use o ntribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by V No 1 Tyes 2 3 Probably 4 Unknown ecords, 4b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy のかこと on on certificate Division of Vital R 25. Was case referred to medical examiner? director, 6. Place of Death (Check only one) Be 2 Hospital Other: ဂ္ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 Dipole 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manney of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred Matural iniury 5 Pending Accident Investigation 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) Medical 🔽 Certifying Physician: To the best of my knowledge, death occured at the 🔭 e, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my vinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of p

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CHON

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ecember 2 2011 Physician/ 5:00PM roold trancis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Med, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Months Days Hours Min. (Month, Day, Year) Country) 79 **Director** 216-28-025 -25-193 Usual Residence of Decedent show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Tes 2 No TOOPER 10g. Citizen of What Country? 10e. Street and Number Funeral 728 400 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Maryland 21215-0036 þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates./952 -Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. ပ္ troold F. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rolyn Uren Nolan Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Curran-Aranwell Funcia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE END Renal disease or condition Medical resulting in death) Due to (or as a consequence of Examiner oronau Sequential list conditions if any, leading to immediate cause. Enter Underlying Exam as the burial-transit Cause (Disease or iinjury Schemic that initiated events resulting in death) Last attending physician Pneumonia Physician/Medical requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Other (specify) Pregnant at time of death signed by the and be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No Division of Vital Records, 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an P Hospital or Attending Physician: The law 124 hours after death. Funeral Director: After this certificate has t autopsy perform Yes 2 No funeral director, Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes မှ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury **X**Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: Ai completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 00061832 6x 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE, GLENBURNE, MD 2106 301 SAMIR AIN 2. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 12 Month 045 Physician/ 1250 Medical Facility Name (if not institution, give street and number 4c. County of Death **Examiner** Aguslawa Mesico WOSHINSON g. Birthplace (State or Foreign If Under 24/Hrs 8. Date of Birth Age (In yrs. last birthday) **Funeral** (Month, Day, Months Marvland Dec. 1924 87 220-18-3386 Director Usual Residence of Decedent artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Maryland | Washington County 1 Yes 2 No Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral permit. Page 1 and 2 should be filed within 72 hours after death with. Department of health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumation." 21742 U.S.A. 20431 Kings Crest Blvd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. rmed Forces Black, White, etc. 1 X Yes 2 1943-If Yes, Give 1943-Year or Dates. 1946 ð 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Executive Director Commission on Aging Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Viola Ruth Hovermale Otto Joseph Ronald Otto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20431 Kings Crest Blvd. Hagerstown, MD 21742 Janet R. Otto-wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Smithsburg Crematory 12-12-2011 Smithsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease or complications that caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying for as a consequence of Exami been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown g | Unknown Part II. Other signiticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director. After this certificate has be funeral director, page 2 : autopsy performed Yes 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, ၀ 1 🗌 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natura injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the f only one) 29b. Signature and title of certified 0

State Registrar (evp

Medicol

11-07223 Blake Oppelt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

паке Орреп	-	State of Maryland / Department of Health and Ment 1- For State Certificate of Death Registrar		eg. No. 201	1 4121
Physician Medical Examine	1	Decedent's Name (First, Middle,Last)	2. Date of Dea Month Septembe	oth Day Year er 25, 2011	3. Time of Death 0443 hrs
Medical Examine		Blake Elias Oppelt 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of		4c. County of Death	
are a	١,	40875 Hawk Court 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year	r 24Hrs. 8. Date of Bi	St. Mary's rth(MM/DD/YYYY) 9. Bir	thplace (State or
Funeral Director		228-43-1393 1X M 2 F 25 Yrs. Wonths Days Hours Usual Residence of Decedent		Foreig	^{n'} Virginia
w any	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show d at once.	<u>ا</u> إ	Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	
the Mar n or 28 tiffed a		40875 Hawk Court 20650		United Stat	es
within 72 hours after death with the Maryland yeare. her than "natural", or items 23a or 28a-f sho "Medical Examiner must be notified at once." Medical Examiner must be notified at once.	<u> </u>	11. Martial Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orig 1 X Never Married 2 Married Armed Forces? 14. Was Decedent of Hispanic Orig 15. Francisco Control of Married 15. Married 16. Married 17. Married 17. Married 17. Married 18. Married 18. Married 19. Ma		o- 14. Race - Ameri White, etc.	can Indian, Black,
		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Whi	te
5-0036 led within 72 hours after lygene. other than "natural", the Medical Examiner.		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give leading most of working life. DO NOT	kind of work done use retired)	16b. Kind of Business/	
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MD 2 12 shou th and h 27 is n	1	Keiko Oppelt/Mother 40875 Hawk Court,	Leonardto	wn, MD 2065	50
re, s I and f Heal If iten		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr	-	4 Donation 5 Other Specify: Lakewood Cemetery 21/Signature of Funeral Service Licensee 22. Name and Address of Facility		Minneapoli	
Dem Depa Injury		Rathleen Santivasci M00872 122955 Hollywood	Brinstiel Road, Lec	d Funeral H nardtown, M	D 20650
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cafailure. List only one cause on each line.	ardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
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		cause. Enter Underlying Cause (Disease of Injury that hilliated			
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876(tificate ng phys as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	c pregnancy	23d. Date of deliver Month	y Day Year
Box 6876 e death certificat the attending phy ed for use as the	Priysician/n	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown			
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Vital Records, F rysician: The law requires this certificate has been sign director, page 2 should be	Completed		auto	opsy prior to formed? death?	completion of cause of
tal Rection The certificate ector, page		25. Was case referred to medical 26.Place of Death		2 No 1 Y	es 2 No
Vita		1 V Yes 2 No		Residence 6 Othe	r: Scene
nding Plus.: After		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 X		e how injury occurred	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director, page 2 should be detached for use as the burial - transition in the funeral director - transition in the funeral director - transition -	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, et	tc. 28f. Location or Town,	(Street and Number or R State) 40875 Ha	ural Route Number, City
Divis ospital or A numeral Dire y filled in E	5	29a. Certifier 4 Continue Physician To the best of my knowledge, death occurred at the time, date and plants.	Leonar	dtown,MD.	
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death ocan manner stated.	curred at the time, dat	e and place, and due to t	ne cause(s)
F 3 F 3	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.	COME	29d. Date signed (Mo	
		Name and address of person who complete cause if death (Item 23a)			
		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Str	reet, Baltimore, M	1D 21223	
Sta Registra		The second of th			

1-08947		Please Type or Print in Black Indelible I	-	_	ole.		
Louis V. Poteat		State of Maryland / Department of Certificate of Ce			201	1 4 2 18	
Physiciar Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Louis V. Poteat	, Dodin	Reg. No. 2. Date of Death Month Da November 28		3. Time of Death 0648 hrs	
		4a. Facility Name (if not institution, give street and number) Prince Georges Hospital	4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	8. Date of Birth(M	1M/DD/YYYY) 9. Bir	thplace (State or	
Director		578-50-0554 1 M 2 F 72 Y	Months Days Hours Min	12/28/1	938 Nor	th Carolina	
nd ihow any ice.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local 10aryland Prince Georges Seat Pleas				10d. Inside City Limits 1 Yes 2 No	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cour	ntry?	
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vithin 7	Completed		Employed		Private		
21215-0036 sold be filed within 7 Montal Hygiens marked other than c event, the Medica	မ္တ	17. Father's Name (First, Middle, Last) Jimmie Louis Poteat		(First, Middle, Maid Corbett	en Surname)		
Baltimore, MD 21215-0036 pernit, Pages I and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturingry or other transatic event, the Medical Exami		19a. Informant's Name/Relationship (Type, Print)	g Address (Street and Number or F	Rural Route Number		, Zip Code)	
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altin mit. Pa partmen portan ury or	ŀ		oln Crematory 12 Name and Address of Facility For				
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r Atten r Atten er deatl rector:	ᇐ	2 Accident Investigation 28e Place of Injury - At home, farm, stre		28f. Location (Stree	et and Number or Ru	ral Route Number, City	
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DIVI To the Hospital or within 24 hours after completely filled in	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur (Check only) 2 Wedical Examiner: On the basis of examination and/or investigation and manner stated.	tion, in my opinion, death occurred a	at the time, date and	place, and due to th	e cause(s)	
		29b. Signature and title of certifier	29c, License number O.C.M.E.		ovember 30, 20		
R 10		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. B.	altimore Street, Baltimore, N	MD 21223			
Sta		31. Date filed (Month, Day Year) 32. Registrar's Signature					
Registra	_	DEC 0 8 2011 Sever B. Apares					

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ORIGINAL

OCASE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mae Ross Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany WM. Regional Medical Center Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 1922 West Virginia 1 🗆 M 2 🔀 March Day Ye 217-14-4099 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director MD Allegany Barton YYY Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral United States 19305 Railroad St 21521 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. or i 1 Never Married 2 Married Completed by Yes 2X No lid be filed within 72 hours after of Mental Hygiene. Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Housework Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry DeShong Ethel Sutton permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Preston/ daughter 23503 Potomac Hollow RD, Barton, Maryland 21521 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/16/2100 LaVale, Maryland 1 X Burial 2 Cremation 3 Removal from State Rest Lawn Mem. Garden 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home Z Way 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months 1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? 1 Yes 2 No this certificate 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Tes 1 III Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of s after death. 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending iniury Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signatu death (ten 28a) (Type. PINESTEAN MAD PERSONAL State **DEC 13 2011** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year EALIE ROBERTA SIRON 201 Medical December 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL COLUMBIA HOWARD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan • 22 Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Maryland Months Days Hours 218-66-4258 75 **Director** Jan. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2 No Brookeville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4586 Route 97 20833 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "naturaumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teachers Aide Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Warrenton V. Bertha 0. Gaylor traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Penny Siron / Daughter 4590 Route 97, Brookeville, Maryland tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 🗹 Burial 2 🗌 Cremation 3 🔲 Removal from State permit. Page Department (Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cemetery 12/9/11 Sunshine, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882 12 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) PNEUMONIA Medical Due to (or as a consequence of) Examiner MMUNOSUPPRESSION Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Dué to (or as a consequence of) as the burial-transit Cause (Disease or iinjury MALNUTRITION that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 Yes 2 No Day Month Year ned by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be de þ if or Attending Physician: The law requires after death.

Director: After this certificate has been sign Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 -No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 E Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D70597 2011

State Registrar

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arke

5755 Cedar Lane, Columbia, MD

21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHMAR

32. Registrar's Signature

CORINNE

DEC

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND TIEM# I perpHYS, G923, 17572012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary Mildred Roberts Month **Physician** 135 PM November 262011 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Villa Rosa Nursing Home Mitchellville Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2X F Days Hours Director 579-14-3340 95 10/23/1916 DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 XYes 2 No MD P.G. Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4817 Trenton Road 20784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ρ White Specify: 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f Fred Hoffman Gertrude Ahmay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum Edward Roberts Jr./Son 1001 Agricopia Dr. LaPlata, Maryland 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 12/02/11 Brentwood, Maryland 21. Signature of Fungral Service Scensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladnesburg, Road Brentwood, MD 20722 noms 11 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ementia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as attending p IF FEMALE: use a 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? res 2 No certificate 1□ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical and manner stated nd title of bearing 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) November 282011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 thream 28355 MU Decey 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 8 2011 back Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 20 41222 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 9:47P M 2. Date of Death Physician/ Month Year Claudia C. Ridley December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince Georges Doctors Hospital Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F Days Months Hours Min 12-23-1948 Country) Yrs. Director 62 579-66-8993 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits death with the Maryland Director notified 1 X Yes 2 No Mitchellville MD Prince Georges 10e. Street and Number

Lake Overlook ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or by Funeral 11200 Lakeover Look Place 20721 United States items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, "natural", or iter edical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) United Airlines Flight Attendant alth and Mental Hyglen 27 is marked other ther er traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Greenhow ၉ Page 1 and 2 should be ment of Health and Ments Claude Dawson Marjorie Greenhouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Toni K. Bowie/Friend 5415 Conn. Ave NW Washington DC 20015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 $\stackrel{\mbox{\scriptsize M}}{\longrightarrow}$ Burial 2 \square Cremation 3 \square Removal from State Lincoln Memorial 12-12-2011 Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home 21. Signature of Fundral Service Lice 3005 12th Street NE Washington DC 20017 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sheek, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ presst cances disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any leading to immediate cause. Enter Underlying Class to for as a passequence offi-Physician/Medical Exam Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown should should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy performe 2 No 2 4 No 1 Yes Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 on 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year, completed cause of death (Item 23a) (Type, Print) 30. Name and ddress of perso 8118 Good Luck ROAD LANGHAM. GANDARI MD 20106 32. Registra's Signa DEC 0 8 2011 State Registrar

DHMH 17 Rev 7/2009

C Aud !A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Alice May SIRROCCO 00 Deemyber 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hagerstown Washington Meritus Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 94 225-98-6033 Yrs Director May 12, 1917 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evantinal must be natified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Washington Maryland Hagerstown 10e. Street and Number Ravenwood Assisted Living 10f. Zip Code 10g. Citizen of What Country? USA 1158 Luther Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 If Yes, Give 1 Never Married 2 Married 1 ☐Yes 2 No Specify ģ Specify: white 3 X Widowed 4 □ Divorced Year or Dates Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Edward Felker Mary Motley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Allen - daughter 2928 Ward Kline Rd., Myersville, Maryland 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State LaCrosse Cemetery 12/10/2011 LaCrosse, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner abdommed viscera 8 hours perforation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and it be detached for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Otner (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 202 No 1 Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After th

completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 Yes 2 No 3 🗍 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

IW- 3

3altimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records.

Division

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Helgestenn 17 D. 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH 6926 4/23/2012 JH of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Agatha PM SELBY December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number 6808 216-58-6806 Funeral . Age (In yrs. last birthday) If Under 24 8. Date of Birth 9. Birthplace (State or Foreign May 13 1925 1 - M 2 X F Davs Hours Director Grenada W. 86 Indies Usual Residence of Decedent 28a-f show 10b. County the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 10332 Lantern Lane 21740 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3X Widowed 4 □ Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. GED Health Care Nursing Assistant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) and Mental F is marked of မ Emil Hector Jane McIntosh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Ann McIntosh - Daughter 10332 Lantern Lane, Hagerstown, Md. 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cypress Hill Cemetery 12/13/2011 | Brooklyn, New York Signature of Juneral Service Licens 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physicin disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last vere Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death be detached the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 X No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 page certificate 1 🗌 Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ဂ္ 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation M within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) upleted filled in by determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Antietam St., #306

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RICHARD

Hagerstown, MD

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217 40

December 06

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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/Medio Examin		4a. Facility Name (If not institution, give s	treet and number)				or Location of Death			County of I	Death		\neg
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Hygie Int. tt		17. Father's Name (First, Middle, Last)			COIL	iputer i	18. Mother's Nar	me (First, Middle	e, Maiden		ernmer	116	
lid be fental rked c	To Be	Charles G. Strail	man				Helen	Allen					
shou and M	•	19a. Informant's Name/Relationship (Typ			19b. Mailing	Address (Stree	et and Number or Ru	ural Route Numb	er, City o	r Town, Sta	te, Zip Code)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: It item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at once.		Virginia M. Strail	man/Wife				rive, Boo		Mary	land	21713		
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perm Depa Impo any I		Disers	C Iron	nen			National 1						
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/Medical		resulting in death)	Due to (or as a			<u> </u>							
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eath certificate be attending physici I for use as the b	Medica	300							1			_	
th cert	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth			Ectopic pregnan	ncy		1	23d. Date o		Year	
e deal	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	time of de	ath 5 □ C	Other (specify)				WOTE	Day	icai	
The law requires that the death certificate be the has been signed by the attending physicial page 2 should be detached for use as the bu		Part II. Other significant conditions con	ntributing to death bu	ıt not resu	ılting in the und	derlying cause	given in Part I.	23e. Did	tobacco u	use contrib	ute to the ca	use of death?	
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death ttend death tor: A / the f	ertification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injur	ry - At hor	ne, farm, stree		Yes 2 □ No	28f. Location	(Street an	nd Number	or Rural Rou	ute Number.	_
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director,	alC	29a. Certifier 1 Certifying Phys											
n 24 l	edical	(check only 2 Medical Examil	and manner state		on and/or inve	stigation, in my	opinion, death occ	urred at the time					
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IW-10		30. Name and address of person who co	mpleted cause of de	eath (Item	23a) (Type, Pi	rint)	600	North We	olfe S	t. Balti	imore	MD. 212	87
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1230 AM Month Day Physician/ William Starkey Robert 4 2011 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 **X** M 2 □ F **Director** 214-42-8093 MARYLAND NOV. 26, 1944 Usual Residence of Deceden or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No **OUEEN ANNE'S** QUEENSTOWN MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō ms 23a or must be n Funeral USA 125 MAINBRACE DRIVE 21658 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 14. Race - American Indian. Examiner Black, White, etc. 6 ģ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 1965–1969 Specify: WHITE "natural" Completed 3 Widowed 4 X Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) traumatic event, the **CANNERY** MECHANIC 12 -0-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EMMA PEARLE DILL WILLIAM H. STARKEY and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 307 HOLLY STREET, CENTREVILLE, MD 21617 VIRGINIA S. LEWIS/ SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State DEC. 8, WOODLAWN MEMORIAL PARK EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral & 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Ventreulan tachyconda with intermetent Pulseless electral Reports disease or condition resulting in death) Medical **Examiner** Fragmin Bactornic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine 560 and Sussequent SB Resections. attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Reabetes Mellities , type-tention, Dyslipidemia. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of death? Obstrutive Sleep Aprila. 24a, Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🔲 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 1 M Natural 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) - Klen, MD Pec. 4, 2011 1861620452

State Registrar Bathmore, MO 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

118 N. Howard Street

22) Registrar's Signature

ANSAR KHAN, MU

31. Date filed (Manth Day, Year) 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SHEETS Physician/ 2011 0512M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Churchton Anne Arundel 5540 Harford St. If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min 2/15/1941 Country) 1 M 2 F 70 577-56-6468 **Director** Missouri Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Churchton Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 ian "natural", or items 23a or Medical Examiner must be i Funeral USA 20733 5540 Harford St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than alth and Mental Hygiene.

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Kalas Crematory 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State 12/6/11 Edgewater, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending 2 No 24 hours after death. Funeral Director: A Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) Signature and title of certifier pleted cause of death (Item 23a) (Type, Print) Name and address of person who ANNAPOLIS MO2401

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

DEC 06 2011

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 30, 2011 2:10 P PAUL SAYLOR DANIEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min. **Director** 216-76-7578 1 **X** M 2 □ F Sept. 3, 1960 Maryland 51 Usual Residence of Deced show ms 23a or 28a-f shor must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No MD Frederick Emmitsburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 26 Zanella Drive items permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status er than "natural", or iter the Medical Examiner Armed Force ģ 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Company Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Grossnickle Hall Emory Saylor Erma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 21727 <u>LaDonna K. Saylor / Wife</u> 26 Zanella Drive, Emmitsburg, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) <u>Resthaven Mem. Grdn.</u> 12/3/2011 Frederick, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Robert E. Dailey & Son Funeral Homes, P.A. 615 East Main Street, Thurmont, Maryland 5 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final - Myo cerebrai Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Sequentially list conductors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and if for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death been signed by the a should be detached Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Lampinged Conw Yes 2 2 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 X No 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2, To the F only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

Narius NY

32. Registrar's Signature

30. Name and address of person who completed cause of death (Vern 23a), (Type, Print)

29c. License number

29d. Date signed (Month, Dav. Year)

Street Frederick, MD 2170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Paul Rodman Sweeny Medical 4a. Facility Name (if not Institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Reeder's Memorial Home Boonsboro Washington 8. Date of Birth If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Year **Funeral** .Sex 1 M 2 □ F Months Davs Hours Min. 1272171923 87 MA Director 096-16-5346 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral USA 13900 Kellen Drive 21740 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 XYes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Advertising Corporate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Adele Vaidis Allen William James Paul Sweeny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13900 Kellen Drive, Hagerstown, MD 21740 Katherine Sweeny / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/12/2011 Smithsburg, MD Smithsburg Crematorium 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FROS TRATE ADVANCED Monie disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner POLY MYALGIA months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): 1) A43 . or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit HOSPILE CARE that initiated events Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 : autopsy 2 No Yes 2 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera work? 1 Yes 2 No 1 Natural 5 Pending injury Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or At within 24 hours after or To the Funeral Direct 4 Homicide determined City or Town, State) Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number pleted cause of death (Item 23a) (Type, Print) × State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar L1230 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <u>Salamone</u>, Jr Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Reeders Memorial Home Boonsboro Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 👿 M 2 □ F (Month, Day, Year) Months Days Hours Min. Country) 92 **Director** West Virginia 1919 235-18-7383 Sept. 13. Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Tes 2 X No <u>Keedysville</u> Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ritems 23a or ner must be n Funeral 21756 3215 Chestnut Grove Road hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or iten ledical Examiner r Race - American Indian. 11. Marital Status Armed Forces?
1

Yes 2 □ No 1 X Yes þ 1 Never Married 2 Married 1942 1 ☐ Yes 2 🗓 No Specify: 3 🕅 Widowed 4 🗆 Divorced White Completed Year or Dates 1945 or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 72 and Mental Hygiene. is marked other than within 7 Elementary/Seconday (0-12) College (1-4 or 5+) 12 Lineman Truck Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည pe Nick Joseph Salamone, Sr. Congetta Anna Fontaine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Sherry D. Martz/Daughter 3205 Chestnut Grove Road, Keedysville, Maryland 21756 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/12/2011 Sharpsburg, Maryland <u>Samples Manor Cem.</u> 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21 Signatur of Funeral Service Licenses 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line.
ediate Cause (Final
ase or condition Immediate Cause (Final Physician/ Cema disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 1 month Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying ysician and e burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last s been signed by the attending physician should be detached for 11se as the burian Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has be irector, page 2 s autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this (completed filled in by the funeral director) this (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a title of certifier

Registrar

15+1 UF

2

State

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 Lagans Rd. Boonsporo MD 21713

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death James Spicer Physician/ 192th 06-2091 1915 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours 10-06-1957 North Carolina 1 M 2 - F 219-58-2331 60 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Directo Havre de Grace 1 X Yes 2 No Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States of America 21078 528 North Adams Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🂢 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Fork Lift Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillie Dunford Bert Oliver Spicer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 29 Walnut Street, Havre de Grace, Maryland 21078 James Spicer, Jr. (son) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 🗆 Burial 2 🛱 Cremation 3 🗆 Removal from State 12-08-2011 WestChester Pennsylvania RA Ferris & Co Inc 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funcial Home. P.A. 21078 123 South Washington St. Havre de Grace. Marylan . Signature of Funeral So Havre de Grace. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SYNTROME Immediate Cause (Final RESPIRATORY ACUSTE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SHOC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown OBSTRUCTION 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death?

1 □ Yes 2 □ No _____ 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of my hitowisedge, death occurred at the time, date and place, and due to the cause(s) and minimal as stated.

Certifying Nurse Fractioner: It is east of my hitowisedgation, in my opinion, and the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D00 12-7-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUTHAWALA 501 S. Union Avenue, Havre de Grace Maryland 21078 32. Regis rar's Signature 31. Date filed (Month, Day, Year) State DEC 2 1 2011 Registrar

DHMH 17 Rev 1/2001

State Registrar Spangle CRNY

31. Date filed (Month, Day, Year)

32. Registral's Signature

CIP 1976, MD. 20646

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Physici		Decedent's Name (First, Middle	,Last)						Date of Deat Month	Day Ye	ar	3. Time of Death
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Funeral				e (In vrs. la	ast birthday)			Under 24Hrs	. 8. Date of Birt			hplace (State or
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		Usual Residence of Decedent	1 2 VI 2 F		05 1	18.			01/13/	1940		rib)
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and show	ō	MD Allega	ny	Li	ttle (rlean	ıs					1 Yes 2 No
Maryli 28a-f 1 at 0	Director	10e. Street and Number				10f. Zip	Code		10	g. Citizen of W	hat Cour	itry?
ith the Maryland 23a or 28a-f sho ootified at ooce,		12604 St. Patr	ick's Road			2	1766			USA		
215-(1036) be filed within 72 hours after death with the Maryland nual Hygiene. rked other thao "oatural", or items 23a or 28a-f she cot, the Medical Examiner must be ootified at occ	Funeral	11. Marital Status 1 Never Married 2 X Ma	12. Was Decedent Armed Forces?	Ever in U.			nt of Hispanic y Cuban, Mex		pecify Yes or No- Rican, etc.)		e - Americ te, etc.	can Indian, Black,
er dez			1 Yes 2 [No	1	7 Van 2	X No spe	- A.S		Cassific	LIL	nite
5-(1036 led within 72 hours afte dygione. other than "oatural", the Medical Examioer	d by	15. Decedent's Education (Spec	or Dates:	pleted)			Occupation (G		vork done	Specify: 16b. Kind of Bi		
72 ho 1 6.08	Completed	Elementary/Secondary (0-12)	College (1-4 or 5				king life. DO N					•
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21215-()0 ould be filed with I Mental Hygien I marked other ic evect, the Me	o Be	Robert Leroy S 19a. Informant's Name/Relationsh			Laoh Mail				S Bloods Rural Route Num			
MD 21215-(1036) 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic evect, the Medical	ပ											
		Doris Jean Scot 20a. Method of Disposition			Place of Disp	osition (Nan	ne of cemetery	K S KO	Date Date	20c. Location	- City or	MD 21766 Town, State
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Baltimore, permit. Pages I an Department of Hea Important: If iter iojury or other tra		4 Donation 5 Other Sp. 21. Signature of Funeral Service I		SIII.			Address of Fa		.4/2011	t Main		
Q 8 9 3 3	/	K. (.)	Alore MC	0260	G ₁	rove F	uneral	Home				750-0368
Physician		23a. Part I. Enter the disease, or of failure. List only one cause of	ómplications that caused in each line.	the death.	Do not ente	the mode of	of dying, such	as cardiac o	r respiratory erre	est, shock, or he	art	Approximate Interval Between Onset and
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		or condition resulting in death)	Due to (or as a conse	quence of	f):							
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ox 687 cath certific attending for use as t	Ä	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at	ime of de	-46	etal death		topic pregna	ancy	Month	D	ay Year
that the death certif red by the attending detached for use as	Physician	1 Yes 2 No 9 Unkr			atn 5 (Other (Spec	ory)					
P.O. es that the igned by the		Part II. Other significant condition	ons contributing to death	but not re	sulting in the	underlying	cause given i	in Part I.	23e. Did to	bacco use cont	ribute to	the cause of death?
ords, P.C w requires that as been signed to should be deta	d by								1 Yes	2 ✓ No 3	Prob	ably 4 Unknown
ords	Completed								24a. Was a			topsy findings available ompletion of cause of
Recc The lavicate ha	E								perfor 1 ✓ Yes	med?	death? 1 ✔ Ye	
Vital F ysiciao: ' ysiciao: ' his certific director, p	ادہ	25. Was case referred to medical examiner?					26.Place of De		only one)			
of Vital Recing Physiciae: The After this certificate Uneral director, page	P	1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗌	ER/Outpatie	nt 3 D	OA Other	4 Nursir		Residence 6		: Scene
n of ding Ph	Ë	27. Manner of Death 1 Natural 5 Pendi	28a. Date of Injur (Month, Day,Ye	y ear)	28b. Time o FOUND:	f Injury 2	28c. Injury at V		28d. Describe h Subject shot		тed	
SiO Atten r death ector: by the	Sati	2 Accident Invest	gation Dec 10, 2011		0845 hrs			2 ✓ No				
Division of Vital Records, pital or Attending Physiciae: The law require our after death. reral Director: After this certificate has been si filled in by the funeral director, page 2 should b	Certification:	deterr	not be 128e. Place of Injuried (Specify) Sing	-		eet, tactory,	, office building	g, etc.	or Town, St 12604 St. Patr	tate)		ral Route Number, City
Hospit 4 hour Fuoer		29a Certifier	rsician: To the best of my			urred at the	time date and	d place, and				
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physiciae: The law requires that the death certificate the Paperal Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as to	Medical		Iner:On the basis of exam									
F > F 8	Me	29b. Signature and title of certifier	and marmor stated.	1	10	290	. License num	nber	-	29d. Date sign	ned (Moi	nth, Day, Year)
		a lu	11	1	1)	O.C.M.E.			December	12, 20)11
1 Pm		30. Name and address of person v		,	,							
	لِ		ssistant Medical Ex			Baltimor	e Street, B	Baltimore,	MD 21223			
St Regist		31. Date filed (Month, Day, Year)	32. Registrar	s Signatu	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G923 1/04/2011 The State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2011 Physician/ Marie E. Stevens December 13 \mathbf{P}^{M} 12:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Record Street Home Frederick Frederick Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1914 9. Birthplace (State or Foreign Social Security Number If Under 1 Year **Funeral** Months Days Hours New York 134-12-2641 97 Director June 29 9141 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location Director Maryland Frederick Frederick 1 😾 Yes 2 🗌 No 10f, Zip Code 10e. Street and Number 10g, Citizen of What Country Funeral 115 Record Street 21701 United States of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: White 3 x Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Musician Music Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ၉ Eugene H. Erlenback Maria A. Tetzler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Record Street, Frederick, Maryland 21701 Kevin Quirk / Administrator 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 16. ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Smithsburg, Maryland 4 Donation 5 Other (Specify) Smithsburg Crematory 2011 22. Name and Address of Eacility **Keeney and Basford P.A. Funeral Home** 21. Signature of Ferenal Sp 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph.sician/ ner disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No should be detached for Month 5 Other (specify) Pregnant at time of death Unknown Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ teo pons 15 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy perform 1 ☐ Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate; 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury 1 X Natural 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the only one 29b. Signature ar 29d. Date signed (Month, Day, Year) D0055061 2011 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aubrie Nagy, M.D. 300 West Ninth Street, Frederick, Maryland 21701 32. Registrar Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 175 2011 DIANE $_{
m LEE}$ SPROUT 4:30 . a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Elkton Cecil Union Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Hours April 10 1947 216-52-7848 Maryland 64 Director Usual Residence of Decedent 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD Elkton 1 Yes 2 No Cecil 10g. Citizen of What Country? U.S.A. 10e Street and Number 10f. Zip Code Funeral 51 Fieldstone Lane 21921 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Albert Wilson, Sr. Elsie Virginia Whitlock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 51 Fieldstone Lane Elkton, MD. 21921 Edwin L. Sprout (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Leeds Cemetery 12/21/11 Elkton, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furteral Service Licensee Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Loa. Part I. Enter The disease, or complications that caused shock, or hen't failure. List only one cause on each line. Immediate Coule (Final disease or bindition resulting in death) Approximate Interval Between Onset and Death Physician/ Medical Due to **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death sate has been signed by the a page 2 should be detached to 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific Division of Vital completed filled in by the funeral director, 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 뎯 2 HNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

8 My

State Registrar (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 8, Donald McPhail Traynor 2011 8:02 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1049 Bramly Drive Washington Hagerstown Social Security Number 7. Age (In yrs. last birthday) Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours (Month, Day, Year) ine 2, 1911 Scotland 216-88-5644 Director 100 June Usual Residence of Decedent 28a-f show 10a, State 10b. County 10d. Inside City Limits with the Maryland notified at 10c City Town or Location Director 1 X Yes 2 □ No MD Hagerstown Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö Examiner must be Funeral items 23a 21742 1049 Bramly Drive Scotland | 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ō δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify: 'natural", Specify: Completed 3 X Widowed 4 □ Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Parks Department 10 Gardner permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Annie McPhail Patrick Traynor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Nave/Daughter 1049 Bramly Drive, Hagerstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 12/9/2011 4 Donation 5 Other (Specify) Smithsburg, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licenses SMarke 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ongestive 9415 disease or condition Medical resulting in death) Due to (or *s a consequence of): **Examiner** 20715 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Varilose Verns Exami burial-transi 4 60716 resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atter d be detached for in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? 2 Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 X N ☐ Yes 2☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes Accident
Suicide Investigation
6 Could not be 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TW-1

MASSOCIO B. ALIZADEH, UD 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

mustons

240 Frederick St. Hagerstown MD 21740

State

29c. License number

D 14800

To the Funeral

State Registra

DHMH 17 Rev 1/2001

OCME 2006

29b. Signature and title of certifie

Laron Locke MD.

2. Registrar's Signature

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

November 30, 2011

and manner stated.

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

5

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | 41238 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December ^D₄, 20 ÎÎ 1:24 A M Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 6. Sex 1 XM 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Days Hours 4-16-1936 Helena, AR 75 Director 432-64-8894 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho Director Hvattsville MD Prince George's 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20782 United States 5403 16th Ave Apt 103 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc þ 1 Never Married 2 XMarried 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced **Black** injury or other traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Washington TIMES Clamp Truck Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Allie McGee Taylor Spurgeon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $5403\ 16th\ Ave\ Apt\ 103\ Hyattsville,\ MD\ 20782$ and 2 s Health a Vanessa Toye (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 12/10/2011 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home Brentwood, MD 20722 3401 Bladensburg Road Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death + therosderobe Cardiovascular discare Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Dav the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Inpatient 2 PER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 1 Matural 5 Pending 1 Yes ☐ Accident Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 12-05-11 D0060 los 341 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alfor INA San (niversity 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:19a M Hazel Thompson Dec. 13 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Golden Living Center Washington Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X F 95 171-24-4724 01-24-1916 **Director** Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show 1X Yes 2 No Director MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 750 Dual Highway 21740 USA Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23aury or other traumatic event, the Medical Examiner must by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: white Specify 3 ₩ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ira F. Shaw Jenny Cornell မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald F. Shaw half-brother 119 Clark Road, Clearville, PA. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any Injury or ot 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawns Mem.Gardens 12-16-11 4 ☐ Donation 5 ☐ Other (Specify) Chambersburg, PA. 1720 21. Signature of Foreral Service Licensee 22. Name and Address of Facility 333 FAlling Spring Rd Thomas L. Geisel Funeral Home M01346 Chambersburg, PA Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or camplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 4 cas disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed ig physician and as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day 5 Other (specify) detached 9 Unknown certificate has been signed by rector, page 2 should be detacl The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2XNo 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death To the Hospital or Attending PI within 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

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nuil Serieli Hagston 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per th g923 1-26-12 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :150 Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 4a. Facility Name (if not institution, ve street and number) ERSTO a (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Jumb467 8. Date of Birth **Funeral** Months Days Hours Min Director items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD within 72 hours after death with the 10e, Street and Number 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important If file m 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be. Funeral Was Decedent Ever in U.S. Armed Forces?
1 № Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates 3 - Widowed 4 - Divorced Completed hit-e 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed wn.. ™al Hygiene. ™er than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) slain should be filed with and Mental Hygien rs marked other th 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2 -12:201 of Funeral Service Licenses 22. Name and Address of Facility Mid Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dring, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximat Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition hermen Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 __ Live Birth 2 __ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? THINK 24a, Was an has autopsy performed? Yes 2 certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 Pyes 2 No Μ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month. Dav. Year) DUDTO40S 122 ress of person who completed cause of death (Item 23a) (Type, Print) 555 Cynwood Drive, Curtis M. Foy, M.D. Easton, MD 21601 Registrar's Sign State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41241 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 12:20PM Mollie Stepp Wilson 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1220 Brunswick Court Arnold 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 334-12-4524 Director 91 1 🗌 M 2 🗓 F Iowa 8/7/1920 Usual Residence of Decede 28a-f show 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland ", or items 23a or 28a-f sho aminer must be notified at 10c, City, Town or Location Director 1 Yes 2 X No Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 USA 1220 Brunswick Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic James K. Stepp Henrietta Moehring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pam Wilson - Daughter 504 Bay Green Drive, Arnold, MD 21012 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 12/6/2011 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician youardial disease or condition resulting in death) Medical Due to (ir as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate course. Each of the course (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year the a ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ypertension 24a. Was an page 2 (autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 🔍 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural 5 \square Pending 2 🗌 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D57531 30. Name and address of personum completed cause of death (Item 23a) (Type, Print)

State Registrar Neg

DEC 06 2011

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

8601 Veterans Hay, Millersville, MD 21108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41242 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Dolores Smith Wimmer December 2:15 Medical p 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Summitt Park Nursing & Rehab. Catonsville 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Days 90 Vrs 08/31/192. Director 220-09-3898 MD Usual Residence of Decede 28a-f shov 10a, State with the Maryland must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Ellicott City Howard 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3001 Greenway Drive 21042 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Wildowed 4 Divorced White Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic even Department of Health and Menta Important If item 27 is marked any injury or other traumations. ၉ William N. Smith Lillian K. Stackemann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna W. Lamparski - Daughter 2521 Burrows Court Williamsburg, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 12/07/2011 Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that/caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sacral Decubitus Ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ne Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been shown that the death. -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retailed
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 XNo Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D30641 December 7, 2011 am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 Ramesh Sabapathi, MD 201-109 Back River Neck Road Essex, MD 21221 31. Date filed (Month Registrar's Signature State all some Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ shington 01 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death **Examiner** Montgomery Fairland Nursing Home Silver Spring If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) 19 **Funeral** 1 🗆 M 2 🛣 F Months Days Hours Min March March 29.47 North Carolina 241-78-2855 64 Director Usual Residence of Decedent 10c. City, Town or Location 28a-f shov 10a State 10b County 10d. Inside City Limits must be notified at Director Md Montgomery Silver Spring 1 XYes 2 □ No 10f. Zip Code or 10e. Street and Number 10g. Citizen of What Country? items 23a 20904 2224 Hidden Valley Lane USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 X Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify. Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Lawyer 7vrs Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Chester Thorpe Maggie Beasley l and 2 should b f Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) (Husband | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 James Neal Washington 2224 Hidden Valley Lane Silver Spring Md permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cheltenham, Maryland Cheltenham Vet CemDec 13,11 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service Licen 21. Signature 22. Name and Address of Facility Tyrone J. Young 5635 Eads Street NE WashD Part 1. 5 the the disease, or con plication what caused the death shock, it earl failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Months Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ Glioblastoma-Brain disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of Stroke 24a, Was an autopsy performed? Yes 2 1 death? 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2X No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 X Natural 5 Pendina n 24 hours after control he Funeral Director: After the funeral in by the fu 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) December 5th 2011 D 28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, M.D. 15245 Shady Grove Road Rockville, Maryland 20850 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Physician/ Month Roland Vernon Warder 2cx Decembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Washington Examiner **Hagers** town Meritus Medical Center Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Apri 1 Pay, 16 , 1931 Marryland 214-28-2680 80 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director Charles Charlotte Hall 1 Yes 2 No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 20622 9880 Trinity Church Rd. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 50-54

If Yes, Give
Year or Dates. 1 ☐ Never Married 2 ☐ Married Black White etc þ filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Naval Research Lab. Elementary/Seconday (0-12) College (1-4 or 5+) Painter Be Father's Name (First, Middle, Last)
Harry Irving Warder 18. Mother's Name (First, Middle, Maiden Surname)
Annie Belle Bowie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9880 Trinity Church Rd. Charlotte Hall, Md. 20622 Vicki R. Underwood (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. Date 17, cemetery, crematory or other place)
Smithsburg Crematory 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Funeral 12525 Bradbury Ave. 22. Name and Address of Facility M01414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Kidney Disease Chronic disease or condition Medical resulting in death) Examiner neumania Sequentially list conditions, in any cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -tran Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IE FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. typerparatyroid; sm 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' After this certificate 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060396 12/13/11

20

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

FARID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MURSHED

112 6

21740

MO

11-09348 Daniel Williams Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

aniel Williams	3	Stat 1- For State	e of Maryla		artment of <i>rtificate of</i>		and	Menta	ıl Hyg	_		201	1	4124
Physici	ian/	Registrar 1. Decedent's Name (First, Middle, L	ast)		rancate or	Death			- 2	. Date of De	Reg. No. ath			of Death
edical Exam										Month Decembe	Day er 12, 20	Year 011	091	0 hrs
		4a. Facility Name (if not institution,	give street and nu	ımber)	1	4b. City, Tov		cation of E	Death			County of Dea	th	
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Funeral Director			Sex	7. Age (In yrs. I	last birthday)	If Under	Days	If Under 2 Hours	Min.		,	D/YYYY) 9. B Fore	ign	State or
Director			<u>x</u> M 2 F	32	Yrs					4/5,	1979	С	ountry)	DE
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with ms 23, be not	Funeral	11. Marital Status		edent Ever in U		s Decedent	of Hispa			cify Yes or N		4. Race - Ame	rican India	ın, Black,
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after al", r	Į.		ed If Yes, Give Yea or Dates:		1	Yes 2 X	-						hite	
hours natur	eted	15. Decedent's Education (Specify			16a. Deceden during m	t's Usual Oc ost of workin					16b. Kii	nd of Business	/Industry	
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Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Filed and Mental Hygiene. Important: If item 77 is marked other than "natural", ur items 23a nr 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	<u> </u>	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address	Street a					or Town, Stat	e, Zip Coo	le)
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Baltimore, permit. Pages 1 ar Department of Her Important: If ite		4 Donation 5 Other Speci	_	oili Gtate	ookview		erv	1	2/1	6/2011	Ris	ing Su	n. MD	
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ព ្ធក្នុធ		foris 9. fr	- p.					en St	ree	t, Ris	sing	Sun, M	D 219	11
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Ψ		Theodore M. King, Jr., M	.//	nt Medical E		900 W. B	altimo	re Stree	t, Bal	timore, M	D 2122	3		
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GARLAND **JEROME** WHITE DEC. 15 2011 6:00P Medical 4a, Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4210 SOUTHWINDS PL. APT.111 WHITE PLAINS CHARLES . Social Security Number 6 Sex 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Months Hours **Director** 1 🕱 M 2 🗆 F 578-32-7829 AUG.25,1925 WASH., DC 86 an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director MD CHARLES WHITE PLAINS 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4210 SOUTHWINDS PL. APT.111 20695 U. S. A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Narried 1XXYes 2 ☐ No If Yes, Give Year or Dates.KOREA Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene, other than " Elementary/Secondary (0-12) College (1-4 or 5+) the should be filed with and Mental Hygier. ACCOUNTANT U. S. GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN J. WHITE SUSIE FEWKES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,20695$ 1 and 2 s of Health a item 27 i PAULINE WHITE /SPOUSE 4210 SOUTHWINDS PL.APT.111 WHITE PLAINS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State **DECEMBER** Department of Important: If it any injury or o 1 Removal from State MD VETS.CEMETERY 21, 2011 CHELTENHAM, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician ONCESTEVIC Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? for Month Year Day 1 Yes 2 No Pregnant at time of death ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed?

Yes 2 page 2 or Attending Physician: The Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 17 Natural 5 Pending s after death. I Director: Af Accident Investigation Suicide 6 Could not be þ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled To the Hospital Medical 29a. Certifier retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29d. Date signed (Month. Day. Year Mel 32. Registrar's Sign tu Registrar

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Carolyn Louise Anderson Physician/ 10:20 PM becember 17. 2019 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Prince George's Examiner Fort Washington 13101 Fort Washington Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. Country A 19977297941 Director 70 1 □ M 2**X**□ F 10a. State MD show 10d. Inside City Limits ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at ob. County Prince George's 10c. City, Town or Location Director Fort Washington 1X Yes 2 □ No 10f. Zip Code 20744 10g. Citizen of What Country? Funeral 13101 Fort Washington Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 X No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Sara Bell McConkey 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be: Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewonce. and Mental is marked c ဂ္ Alexander John Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond L. Anderson Jr./Son 13101 Fort Washington Road, Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 12/21/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on: the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Box 68760 ast IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠/-g ☐ Unknown g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No Division of Vital Records, 1 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a Was an page 2 has autopsy performed? death? certificate 1 Yes 2 No Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2**X** XNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after within 24 hours a To the Hospital 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one completed cause of death (Item 23a) (Type, Print) KENMORE AUC #1018 ALIX, UA 2736 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician /Medicai Examiner

Physician

/Medical

Examiner

Funeral

Director

rai", or Items 23a or 28a-f show Examiner must be notified at

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Funeral

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Pages 1 and 2 should be filed within 72 hours after

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permit. Pages 1 and 2 should be Department of Health and Mental important: If Item 27 is marked any Injury or other traumatic evonce.

Maryland 21215-0036

Baltimore,

Examine Physician/Medical Completed

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Certification:

ical

2 ☐ Accident

3 ☐ Suicide

(Check only one)

attending physician and as this certificate After

The law requires that the death certificate be executed or Attending Physician: within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760

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6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ⊁ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064533 MYSICIAN 30. Name and advess of person who completed cause of death (Item 23a) (Type, Print) LEVI NO ALE HESREW CALLATRIC 2434 W BELVEDERE AVE BALTIMORE mi BABATUNDE AJANI 31. Date filed (Month, Day, Year)
DEC 2 7 2011 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year : 15 A M Physician LICE LE TANDER 25 011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A LEVINDALE HEBREW HOME BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 08/05/1927 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 201 MD 84 Director 213-26-7767 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show at 1 ☐ Yes 2 No 28a-f sh notified Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number death with Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 7904 BROOKHAVEN ROAD 21244 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 0 Specify: WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 **SECRETARY** LEGAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fact of Health and Mental Fint: If Item 27 is marked of **ISADORE** ELFENBEIN LILLIAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) IRWIN ALEXANDER / SON 851 N SAN VICENTE BLVD., #113, WEST HOLLYWOOD, CA 90069 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PARK 12/26/2011 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lice see 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT 'hysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) Completed by Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): physician ar attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a TVAS 2 NO 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARRYTHMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 2□ No 1 2 No 26. Place of Death Check onl one 25. Was case referred to medical Be Hospital: Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation Injury 1-Natural within 24 hours arter co...

To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier

7 State Registrar

SARATUNDE 31. Date filed (Month, Day, Year)
DEC 2 7 201

2434 W-BELVEDERE AVENUE BALTIMORE MS 21215 m) 32. Registrar's Signature

PHYSICIAN

AJANI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE MERILEN COLLARTIC CTL.

10064533

12-25-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Desedent's Name (First, Middle, Last) Physician/ Month 11:59 PM DECEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SINAI HOSPITAL BALTIMORE OF If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth LOUISE Funeral Days 1 □ M 2 😿 F Min 237-62-945 Director Usual Residence of Decedent shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at Director 1 ☑ Yes 2 ☐ No or 28a-f more 70H 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21215 items 23a USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. ō 1 ☐ Neyer Married 2 ☐ Married Completed by 1 ☐ Yes 2 ☐ No If Yes, Give and 2 should be filed within 72 hours after 1 Yes 2 W Specify. 3 Widowed 4 Divorced "natural" Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Maryland 2121 May (0-12) College (1-4 or 5+) BARSHELL Be မ 19b. Mailing Add Baltimore, 20a. Method of Disposition 20b. Place of Dispositio Page 1 a ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sign of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear vailure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE 3 CANCER CERVICAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause E ter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

manufaced filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6

Other (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License numbe 12/21/201 RES - 000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMOU CHERRICK 21215 MD. SINAI HOSPITAL OF BALTIMORE, 2 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 41251 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 3'. 00 A M -P.S.S.10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba Himor Randal Hown NOW HOWEST 9. Birthplace (State or Foreign Country) Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Months Days Hours (Month, Day, Year, 243-30-2018 Director 05-05-Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director BAUTIMORE MD 1 Yes 2 INo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA DLMAN 21215 AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE HOUSEKEEPER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ ARGO SANDERS TOLA KING permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLENN GITEN CIRCLE. PIKESVILLE, MD. 21208 MILLER (DAUGHTER VERLENA Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)

DRUID RIDGE 1 X Burial 2 Cremation 3 Removal from State 12/30/2011 BALTIMORE, MO 4 Donation 5 DOther (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCUS PA 4905 ROAD. BALTIMORE, MO. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a lonsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or activing Cause (Disease or iinjury Examine Due to (or as a consequence of): the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Dav Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been signated to 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No this certificate has **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 2-No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 Accident Investigation 6
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year 10056632 2011 my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gar die Ram del Wirmin 011 Court KC J401

Registrar

State

31. Date filed (Month, Day,

		1 - State Registrar 1. Decedent's Name (First, Middle, Last)			Certificate of	f Death	2. Date of Death	g. No.	3. Time of Death
Physici	an						Month	Day Year	954 pm
/Medic		Eston Lee Bonner 4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town	or Location of Death		4c. County of Dea	
Examin	er	FRANKLIN SQUAR		Tal		osedal.		Baltin	nore
Funeral		5. Social Security Number 6. Sex		n yrs. last birth	day) If Under 1 Yea	r If Under 24 Hrs.			thplece (State or Foreign ountry)
Director		236–48–2918 Usual Residence of Decedent	M 2 F	79 ^Y	rs. Months Day	s Hours Mill.	12/26/19	931 Wes	t Virginia
be filed within 72 hours after death with the Maryland tall Hygiene. and other than "naturel", or items 23a or 28s-f ahow event, the Modital Examinal mattite notified at	tor	Maryland Baltimore		Oc. City, Town Esse					10d. Inside City Limits 1 ☐ Yes 2X No
3a or 28	I Director	10e. Street and Number 627 Delaware Avenue	9		10f. Zip Code 212		10	Og. Citizen of What Co U.S.A.	ountry?
ms 2	Funeral	11. Marital Status	2. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent o	f Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No-	14. Race - Am	
ors after of, or its	by	1 ☐ Never Married 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1XXYes 2 □ No	Korea	1 ☐ Yes 2 ☐XN		o i iioaii, 6:0./	Canaite	hite
in 72 ho	Completed	15. Decedent's Educ (Specify only highest grade	completed)	1 1	Decedent's Usual Occ Give kind of work don life. DO NOT use reti	ne during most of wor		16b. Kind of Business	/Industry
with liene.	шо	Elementary/Secondary (0·12)	College (1-4or 5+)	Pla	sterer			Construct	ion
filed I Hyg othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	faiden Sumame)	
lid be fenta rked ric ev	To B	Ernest Bonner				Sylvia	Burns		
should and Men mark umatic		19a. Informant's Name/Relationship (Typ	oe, Print)	19b.	Mailing Address (Stre	et and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)
and 2 ealth a m 27 is		Mearle Bonner (Wife	∍)	6	27 Delawai	ce Avenue,			
of He		20a. Method of Disposition 1 □ Burial 220 Cremation 3 □ Re		20b. Place of I cemetery	Disposition (Name of r, crematory or other p	lace)	Date 2	20c. Location - City of	Town, Stete
Pages 1 nent of H ant: If ite ury or oth		'4 □ Donation 5 □ Other (Specify)	anioval noin State	Bayvie	w Cremator	ry 12/2	4/2011 I	Baltimore,	Maryland
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, tha Magnes.		21. Signalure of Funeral Service License	θ		22. Name and Add	ress of Facility Bruzdzinsk 1 Fastern	i Funera. Avenue, 1	l Home, P. Essex. Mar	A. yland 21221
84.00		23a. Part1. Enter the disease, or complice shock or heart failure. List only on	cations that caused the	e death. Do no					Approximate Interval Between
Physician /Medical Examiner cian and purial-transit	ai Examlner	Immediafe Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence o	f):	aortic	aneur	\(S M	
	Medica	IF FEMALE:	3c. If yes, outcome of	Drach and				20d Date of d	line.
that the death c	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2 [4□Pregnant at tirr 9□Unknown	Fetal death	3 ☐ Ectopic pregnal 5 ☐ Other (specify)			23d. Date of de Month	Day Year
uires that n signed b	þ	Part II. Other significant conditions con	tributing to death but r	not resulting in	the underlying cause	given in Part I.			to the cause of death? Probably 4 □Unknown
or the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. On the Funerel Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Completed						24a. Was a autops perform	y prior to ned? death?	utopsy findings available completion of cause of s 2 \(\subsection \) No
ian: rtifica ctor.	Bec	25. Was case referred to medical				26. Place of De	ath (Check only on	θ)	
g Physic ter this ce	2	27. Manner of Death	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Y		me of 28c. In			ence 6 Other (Sp ow injury occurred	ecify)
ath. or: Aff	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,			☐ Yes 2 ☐ No			
al or Atte safter de l Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (· At home, fan 'Specify)	m, street, factory, offic	Ce .	28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examir one)	sician: To the best of refer. On the basis of example and manner stated	camination and	death occurred at the Vor investigation, in m	time, date and place y opinion, death occ	e, and due to the caurred at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
o the	Me	29b. Signature and title of certifier	Λ. Λ	P		ense number	2	9d. Date signed (Mor	nth, Day, Year)
		> X A	fret	-en	Y 0:	57613		12-21-	2011
1.1			, ,		- 1				
14/1/		30. Name and address of person who co	mpleted cause of deat	th (Item 23a) (Type, Print)				,
WY M		'	u-Ghard	10 9	Type, Print) 000 FR	Anklin S	Square	DR Balt	o md 21237

Records, Division of Vital Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

Be

Certificate:

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? perform Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗌 No Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 \square Pending wor 1 Tes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m. D.6565N.Ch--ksst #201 B. Ho. md 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

3. Time of Death

6:05 P M

9. Birthplace (State or Foreign

Baltimore, MD

10d. Inside City Limits

1 X Yes 2 No

Services 1234

Approximate Interval Betweer

Onset and Death

20, ^{Year} 11

14. Race - American Indian,

Black, White, etc.

Registrar

31. Date filed (Month, Day, Year)

27

DHMH 17 Rev 06-2011

32. Registre 's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra 1-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ECEMBER 33,3011 21:59 PM **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Sept. 22, 1959 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 🗆 M 2 🔀 F West Virginia 217-74-6314 52 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No N/A Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Numbe United States 21224 817 S. Tolna Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify If Yes, Give Specify: \$ 3 Widowed 4 Divorced Year or Dates "natural", Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) other than Elementary/Secondary (0-12) Disabiled 12 N/A Disabiled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event, ones. Be Constance J. Basham Robert O. Bland မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Joyce A. Bland(Sister In Law) 1530 Redfield Road Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State (Baltimore County) 20a. Method of Disposition Tuesday 1 Burial 2 Cremation 3 Removal from State Holly Hill Memorial Gardens Dec. 27, 2011 Middle River, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. CFSP 22 Name and Address of Facility Service Licensee Jeffrey L. Gair, Sr. CFSP 22 Name and Address of Facility Services Funeral and Cremation Center, P.A.

1. J. Canta A. Lic. #M00677 2325 York Read Timenium, Maryland 21093-2215 23a. But I anter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EARS CARDTOVASCULAR **Physician** TRITERIOSCIEROTIC disease or condition resulting in death) /Medical Due to (or as a consequence of) YEARS Examiner MYPERTENSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and I for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Tectopic pregnancy Day in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the at ald be detached f 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed should be d þ 2 No 3 Probably 4 No nknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 \ page 2 has 2 🗌 No 1 🗌 Yes 1 Tyes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🐪 🗸 1 🗌 Inpatient 2 R/Outpatient 3 DOA ٩ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 5 Pending investigation Injury 1 Yes 2 No М death. 2 Accident the 1 al or Attend safter death Director: Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

C 19 31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

42

32. Registrar's Signature

535

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25, 2011 December 2:50 A M Stanley Rex Bice, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens Montgomery Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** $^{\text{(Month}}_{23}$, $^{\text{Day, Year)}}_{1934}$ 1 X M 2 D F Days Hours Min Months Washington, 212-30-9090 Yrs Jan 77 DC Director Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State irector 10c. City, Town or Location 1 X Yes 2 No MD Montgomery Silver Spring 這 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3152 Gracefield Road MS308 20904 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. United Methodist life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 2 should be filed with h and Mental Hygien. 7 is marked other th Church Clergy traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stanley Rex Bice, Sr. Louise Humphries 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ye 1 and 2 s t of Health a If item 27 i Churalene M. Bice /spouse 3152 Gracefield Rd. MS308, Silver Spring, MD 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Important: If any injury of once, 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory Dec 30, 11 Odenton, Maryland 22. Name and Address of Facility Donaldson Funeral HOme, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 Signature of Funeral Service Lizensee M00773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease Years Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown the detached 9 Unknown signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Spinal Stenosis 1 Yes 2 No 3 Probably 4 X Unknown 2 should I Were autopsy findings available prior to completion of cause of death? 24a. Was an Neuropathy autopsy performed? Yes 2 X No certificate has page 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 💢 No 9 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🗶 Natural 5 Pending injury 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Box 68760 P.O. Records, Division of Vital Hospital or Attending 24 hours after death. 24 hours after deat Funeral Director. filled in by

> State Registrar

Medical

29a. Certifier

(Check

only one 29b. Signature and title

31. Date filed (Month, Day, Year

DEC 2 7 2011

of crtifler

S. Machado, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D24035

3110 Gracefield Road, Silver Spring, MD 20904

City or Town, State,

29d. Date signed (Month, Day, Year)

December 25, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per fh 9928 6-13-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 22,201 a 7:40 P.M John Joseph Burns, Ph.D. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death

Baltimore County Examiner Towson Gilchrist Hospice Center Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Dec. 16, 1925 326-24-3973 86 Chicago, Ill. 1 XM 2 □ F Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location at Director notified 1X Yes 2 ☐ No Maryland N/A Baltimore 10g. Citizen of What Country ō 10e. Street and Number 10f. Zip Code must be United States 23a 21215 Funeral 2707 Manhattan Ave. items 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Examiner Black, White, etc. 6 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. W. W. II White "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Nuclear Elementary/Secondary (0-12) College (1-4 or 5+) Regulatory Commission the Mechanical Engineer 12 80 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed.
Department of Health and Mental Himportant: If item 27 is marked ott
any injury or other traumatic even Catherine Hill John Joseph Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21215 (Son) 2707 Manhattan Ave. Mr. James P. Burns,Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of Saturday 20c. Location - City or Jown, State (Harford County) cemetery, crematory or other place)

Fyans Funeral Chapel and
Cremation Services, Inc. 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland Dec. 24, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Jeffrey L. Gair, Sr. OSP Perceful Alternatives Funeral and Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 Fort 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ hom(c disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Records, P.O. Box 68760 as 1 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery ρ in the past 12 months? Year Month Day ed by the a detached f Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ van 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy page performed? 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 🗌 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) Manner of Death

Natural

Accident 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? injury 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the ful 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29c. License number 29b. Signatu 29d. Date signed (Month, Day, Year) December 22 2011 CXI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) moson no M) GOIN a 31. Date filed (Month, Day) Year) 2. Registrar's Signature State Registrar

010 20 13 らろ DECEMB 民

For State Registrar

Physician/ Herman Franklin Bell, III December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. (Month, Day, Year) 149-42-2133 Director 1 **X** M 2 □ F Mar 6, 1951 60 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location Director Gaithersburg Maryland Montgomery 5 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be by Funeral 9116 Bannister Lane 20879 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. Armed Force 1 Never Married 2 X Married Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Clergy 4 Be Maryland 17 Father's Name (First Middle, Last) and Mental H မ Purnell Garris Herman Bell, Sr. 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kim L. Williams-Bell / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burlal 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/28/2011 of Funeral Service Linense 21. Sign MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician colon cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 /es, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

A stime of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Matural 5 Pending 1 Tes 2 No To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fi the 1 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29c. License number December 20, 2011 43083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 George A sotos, MD Drive, #300, Rockville, maryland 20850 medical center 9707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41257 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 1:03 A^{M} 4c. County of Death Montgomery 9. Birthplace (State or Foreign New Jersey 10d. Inside City Limits 1 Yes 2 X No 10q. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc Afriçan American 16b. Kind of Business/Industry Religious Organization 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9116 Bannister Lane Gaithersburg, MD 20879 20c. Location - City or Town, State Woodbine, Maryland Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 4 Y COVS 23d Date of delivery Day

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0704 20 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Balto 050 30 m 9. Birthplace (State or Foreign If Under Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min. (Month, Day, Year) 3080 **Director** 1 □ M 2 🗷 F 92 -191 Carolin lorth or 28a-f show notified at 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f «h» 10a. State 10b. County 10d. Inside City Limits **Funeral Director** 1 ♣ Yes 2 □ No fimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be a u.s. 100 21201 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Deceueii 2.2 Armed Forces? 1 ☐ Yes 2 ₩ No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 ⅓ Widowed 4 ☐ Divorced Blac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working ite. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ 0 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Kerneth Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 Q Other (Specify) 0-2011 21. Sign ur of Funeral Service License 0) Þ 2121 Û 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ot Dance en ancer nowns disease or condition Medical resulting in death) Due to (or as a consequence of) *Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran 24 hours after death. • Funeral Director: After this certificate has been signed by the attending physician and • Funeral Director: المناطقية المناطقية المناطقية المناطقية المناطقية المناطقية المناطقية المناطقية المناطقية Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year q Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 65 Other (Specify) ျှ 1 Yes 2 **N**ONO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural N 5 \square Pending work? Accident Investigation 2 No Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature nd title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day,

DEC 27

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AA-COV

(Type, Print)

32. Registrar's gnature

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NOPENT

N. Charles

26 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41259 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 4:45 PM JORDAN S BLOOM DECEMBER Medical 4a. Facility Name (if not institution, give street and number) Examiner Location of Death 4c. County of Death 08 timage N/A If Under 24 Hrs. Social Security Number 8 Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Min (Month, Day, Year) Months Hours 214-24-3304 **Director** 1 🕅 M 2 🗆 F 08/13/1927 MD 84 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? ō 10f. Zip Code Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r Funeral 9 RED CEDAR COURT 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Sloom Jakoth Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed WHITE Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) DENTIST DENTISTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BENJAMIN BLOOM DORA GOLDMAN 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RED CEDAR COURT, BALTIMORE, MD CAROL BLOOM/WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/19/2011 BALTIMORE, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Scart 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as curdiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between On et an Death Immediate Cause (Final Physician disease or condition resulting in death) Medical as a consequence of Examiner a Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Medical that the death certificate be P.O. Box 68760 IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Unknown Unknown signed by t Part II. Othersignificant conditions contributing t 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: ပ 🛮 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending injury I Director; A' 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check efffying Nurse Prantitioner: of certifier 29b. Signature 29d. Date signed (Month, Day, Year) 2649 of person who completed cause of death (Item 23a) (Type, Print) amns mura 31. Date filed (Month, Day, Year) Registrar's Si nature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 22 201 BRUNDIGE 8:21 PM TRUEHEART WINSTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birtl **Funeral** 1 XXM 2 🗆 F Months Days Hours Min. MaryTand 0997691920 217-12-9976 91 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location must be notified at Director 28a-f XX Yes 2 No Baltimore Maryland| None 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21210 4301 Roland Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Armed Forces?

1 XIXes 2 No WWII

If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 XX Married 1 ☐ Yes 2XXNo Specify Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Private Practice Attorney Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Nellie Trueheart Thomas Worthington Brundige Jr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 4301 Roland Avenue Baltimore, Maryland 21210 Mamie Nicholson Brundige 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1XXBurial 2 Cremation 3 Removal from State Druid Ridge Cemetery 12/27/2011 Pikesville, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only o lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ LEUMONIG disease or condition Medical resulting in death) Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): led by the attending physician detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Gulure 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To ospira.
4 hours after deam.
Funeral Director: After this c DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 \square Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital within 24 hours a

To the Funeral E

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature d title of certifie 29c. License number 29d. Date signed (Month, Day, Year) December 23 2011

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

6701 N. Cuchis

TON SON MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANCES

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32. Register's Sign

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For	Please	Type or Pr State of N		l / Depa	rtment of H	lealth and	_		Legible.		
Physicia	n/	State Registrar 1. Decedent's Name (First	st, Middle, Lasi	t)		Cer	tificate of <u>C</u>	Death	2. Date of De		201	3. Time of Death	_
Medic Examin	al	Elda Bartz 4a. Facility Name (if not in	nstitution, give				4b. City, Town, or		December 1	4c. County of Death			_
Funeral Director		The Village 5. Social Security Number 392-03-798		t birthday) Yrs.	Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Bit Month Days Hours Min. Month Month Days Month Days Month Days Month Days Month Month Month Days Month Mo			Montgomery 9. Birthplace (State or Foreign Country) Wisconsin					
-	tor	Usual Residence of Dece				Town or Loc						10d. Inside City Limits	_
ith the Mar 23a or 28a- st be notifie	Funeral Director	MD Montgomery 10e. Street and Number 9701 Veirs Dr.			Rockville 10f. Zip Code 20850			<u></u>	10g. Citizen			1 ☐ Yes 2 💢 No puntry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 3 X Widowed 4	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	ent Ever in U.S. 13. Was Decedent of His If Yes, specify Cuban 1 □ Yes 2 🕅 No			ispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
ithin 72 hour ene. • than "natu he Medical	Completed		Decedent's Econly highest gra		5+)	(Give F life, D	ent's Usual Occupating of work done of NOT use retired)	ation Junng most of w	o <i>rki</i> ng		nd of Business		
ld be filed w Mental Hygi arked other atic event, t	To Be	17. Father's Name (First, August Hen			18. Mother's N	Surname)							
nd 2 shou ealth and m 27 is m ner traum		19a. Informant's Name/F Jan Look:	inbill			750	g Address (Street a 01 Glenno	n Dr; B	Rural Route Number	Mary	land 20)81/ 	
. Page 1 a tment of H tant: If ite jury or otl		20a. Method of Disposition 1 Burial 2 Cr 4 Donation 5	remation 3 🗆 Other (Specif))		metery, cren	sition (Name of natory or other plac		Date		cation - City or	Town, State	
permit Depar Impor any in		m	ald S.	Nade of Div	ector			Baltimor	e St; Ba	11tim			
Physician/ Medical Examiner Lial-transit	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death Due to (or as a consequence of):											
0 77 7	Physician/Medical	IF FEMALE: 23b. Was decedent pregint the past 12 montions and the past 12 montions are presented by the past 12 montions and presented by the past 12 monte	hs?	d	n 2 🗀 Fetal at time of de	death 3	Ectopic pregnand Other (specify)	y		:	23d. Date of de Month	olivery Day Year	=
uires that the n signed by uld be detac	þ	Part II. Other significant	t conditions co	ontributing to death	but not resul	Iting in the u	nderlying cause giv	en in Part I.				o the cause of death?	1
The law req	Completed										prior to death?	utopsy findings available completion of cause of s	
hysician: this certific	To Be	25. Was case referred to examiner? 1 Yes 2 No	-	Hospital: 1 ☐ Inpa	atient 2 🗆 E		t 3 DOA Othe	4 L Nursing	Home 5 ☐ Res			cify)	
Attending P r death. ector: After t by the funers	Certificate:	27. Manner of Death 1 Natural 5 [2 Accident 3 Suicide 6 [4 Homicide	28b. Time of injury					d Number or Ru	ural Route Number,				
Hospital or 4 hours after uneral Dir ted filled in 1	Medical Ce	29a. Certifier 1 2 C	Aedical Exami	sician: To the best ner: On the basis of	examination	and/or invest	igation, in my opinio	on, death occurre	, and due to the c	and place,	d manner as st	cause(s) and manner state	ed
To the I within 2 To the I complex		29b. Signature and title of	of certifier	e Practioner: To the		-	29c. License	e number		29d. Dat	te signed (Mont	th, Day, Year)	
		30. Name and address of SAMUEL (f person who c	completed cause of	death (Item 2	23a) (Type, F	Drive R	Pockull	(Mary	land	2089	50	_
Stat Registra	е	31. Date filed (Month, Da	y, Year) 2 7 2011	32. Regis	trar's Signatu	far far	الما						_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ı	_ State	State of Maryland / Dep	artment of Health a tificate of Death		0011 1100		
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of Death	Reg. I	No. 2 3. Time of Death		
П	Physicia		Samuel Bes	~ /		Month	Day Year 8 50 M		
المدر	Medic Examir		4a. Facility Name (if not institution, give stre LOCH RAVEN CLC	eet and number)	4b City, Town, or Location of Bath mare	Death	4c. County of Death		
T.	Funeral Director		5. Social Security Number 212-46-4297 6. Sex 1 X	M 2 \square F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Birth Min. (Month, Day, Year Aug 2 I • I	9. Birthplace (State or Foreign Virginia		
	faryland Ba-f show Lified at	Director	10a. State 10b. County MD Baltimo:	re Randal			10d. Inside City Limits 1 ☐ Yes 2 🖁 No		
	s 23a or 2 s ust be no	Funeral Di	10e. Street and Number 3417 Barry Paul 1	Rd; Apt T1	10f. Zip Code 21133		Citizen of What Country? USA		
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ठ	11. Marital Status 12 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	Was Decedent of Hispanic Origing f Yes, specify Cuban, Mexican, 1 ☐ Yes 2 【 No Specify:	ก? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: black		
21215-0036	/ithin 72 hou lene. r than "nat i the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12) 1 2	College (1-4 or 5+) (Give life. D	dent's Usual Occupation kind of work done during most o O NOT use retired) Stodian	of working 16b.	. Kind of Business Industry unk		
e, Maryland	should be filed w and Mental Hyg is marked othe raumatic event,	To Be	17. Father's Name (First, Middle, Last) Julius Best		18. Mother's Name (First, Middle, Maiden Surname) Vietta Lenore				
	and 2 shoul Health and I em 27 is ma ther traums		19a Informant's Name/Relationship (Type, Julius Best — bro	other 19b. Maili	ng Address (Street and Number Emelia Woods (or Rural Route Number, City Ct; Baltimore	or Town, State, Zip Code) • MD 21206		
	permit. Page 1 and Department of Hea Important: If item any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	in state	natory or other place)		Location - City or Town, State		
Bai	permit Depar Impor any in	ı İ	21. Si , at ire of Fine al Service Licensee Ronald W	ne Director		nore St; Balt	imore, MD 21201		
	Physician/ Medical Examiner	S 9	23a Part 1. Enter the disease, or complications, or heart failure. List only one disease or condition resulting in death)	Due to (or as a Sequence of):	er the mode of dying, such as ca	mphoma	Approximate Interval Between Onset and Death		
	te be executed lysician and ne burial-transit	al Examiner	Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last						
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours a ler death. Or the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year		
ls, P.O.	uires that the signed by ald be detac	ρ	Part II. Other significant conditions contr	ibuting to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
Division of Vital Records,	The law require tate has been si page 2 should l	Completed				24a. Was an autopsy performed'			
tal	cian: certific ector,	Be	25. Was case referred to medical examiner?	spital:	26. Place of Death	(Check only one)			
Ž	Physi this cral dir	일	1 Yes 2 No Posth	1 ☐ Inpatient 2 ☐ ER/Outpatie 28a. Date of injury 28b. Time o	nt 3 L.I DOA 4 Nun	sing Home 5 Residence			
sion o	Attending death. ctor. After y the funer	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year) injury 28e. Place of Injury - At home, farm, str	work? M 1 ☐ Yes 2 ☐ N				
Ö	To the Hospital or Attending Physician: The law within 24 hours a redean. To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 and page 2 and		4 Homicide determined 29a. Certifier 1 Certifying Physicia	building, etc. (Specify)	reet, factory, office 28f. Location (Street and Number or Rural Route Number City or Town, State) occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	To the Ho. within 24 h To the Fur	Medical	(Check 2 Medical Examiner		tigation, in my opinion, death occ	curred at the time, date and pla and place, and due to the caus	ace, and due to the cause(s) and manner state		
	->		30. Name and address of person who com	pleted cause of death (Item 23a) (Type	D2376	7 2	Batto. Ndzizis		
1			DEBRAS WERTH	EINER MD 390	00 Lock Rave	Blud,	Batto. Ndzizis		

State Registrar 3900 Loch Raver Blud, Batto. Mdz1218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b, c per fh 992 12-27-11 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ RBERT RMa Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 182-28-7138 **Director** 1 🛛 M 2 🗆 F 80 05/23/1931 PA Usual Residence of Decedent 28a-f show 10b. County 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director 1 Tes 2 X No MD BALTIMORE REISTERSTOWN 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12020 REISTERSTOWN ROAD 21136 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 72 hours after 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed WHITE event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5 + Elementary/Secondary (0-12) + PRINTING OWNER and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BERMAN JOSEPH BERMAN EDITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra RANDY REISFELD / DAUGHTER 7 LAKESHIRE COURT, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) c, Location - City or Town, State 26ate Trevose ō 1 🗓 Burial 2 🗆 Cremation 3 🗓 Removal from State **Jepartment** 4 Donation 5 Other (Specify) ROOSEVELT MEM. PARK 12/23/2011PHILADELPHIA, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ meumin disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 Yes 2 9 Unknown should be detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Accident injury work? 5 Pending 2 No Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number o completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 06-2011

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ember 21,2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Raltimore Johns Hopkins Bayview Medical Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🔀 F 213-40-144 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ardment of Health and Mental Hygiene.
ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notifiled at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number by Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HUMEN AKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) EreSAM. 1500 rughter 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State Arundel Cran OdeNton, M 5 Other (Specify) 4 Donation 21. Signature of Juneral Service Licensee S. CONKling Approximate Interval Between Onset and Death Part + Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or fleat the complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or fleat the complications that caused the death. Immediate Caus (Final disease or condition resulting in deat) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed ttending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregn in the past 12 months 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached in 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate has 2 10 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 12 Inpatient 6 Other (Specify) 1 Tes 202 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No s after death. 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide e Funeral C 1 pri ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 053850 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 ChWAR State Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Eacility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death unty of D 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Director 8 0 1 M M 2 D F 10-15-1931 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County IOc. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Be 18. Mother's Name (First, Middle, Malden Surname) ည -ar Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or 0 20a. Method of Disposition Place of Disposition Date 200 Location - City or Town, State or other place 1 Burial 2 Cremation 3 Removal from State emetery, cremato 4 Donation 5 Other (Specify) Signature of Fungal Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Ph_sician/ 105 Medical resulting in death) Examiner Sequentially list conditions, many, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day signed by the at Id be detached fo Pregnant at time of death 2 No Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably Wunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy perform death? Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title who completed cause of death (Item 23a) (Type, Pring 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene per dr., g923,01/06/2012dhb Certificate of Death For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Cohen December Julius Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Country)
New York Months Days Hours Min (Month, Day, Year) 04/16/1926 Director 111-18-4277 1 **X** M 2 □ F 85 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No MD Montgomery Bethesda 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8300 Burdette Rd. #C756 20817 United States items death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 þ 1 😾 Never Married 2 🗌 Married 1 ☐ Yes 2 🛣 No If Yes, Give 72 hours after Maryland 21215-0036 1 🗆 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: "natural" White Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Research/ and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Physicist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Department of Health and Moht, Important: If item 27 is marked any injury or other. Hyman Cohen Mohrer Jenny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Viti Fiorentino / Attorney 12505 Park Potomac Ave. 6th Flr. Potomac, MD 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Chesapeake Crematory 12/22/2011 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Signature of Funeral Service M00382 Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ASPIRATION PNEUMONIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examine Due to (or as a consequence of): that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death Yes Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? certificate 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 💢 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred eral Director: After filled in by the funer 1X Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year) ddress of person who completed cause of death (Item 23a) (Type, Print) ROHATGI M.D., 8600 OLD GEORGETOWN RD., BETHESDA, MD 20814

Registrar

(Month, Day, Year)

parel

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 41267 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Mary Margaret Campitelli .2011 10:35 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Gilchrist Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Feb. 9, 1931 212-28-9669 Maryland **Director** 1 □ M 2 🛣 F 80 Yrs 28a-f shov 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location Director notified Parkville 1 Yes 2X No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 21234 9611 Oak Summit Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. 9 þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify: white Specify. "natural", Completed 3 ₩ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. At Home Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H ဂ္ Elizabeth Anna Hess Charles Hennigan, Jr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Grady Lane-Bel Air, Maryland 21014 ge 1 and 2 sl it of Health a if item 27 is Jacquelyn Mathison-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens Of Faith 20a. Method of Disposition Date 20c. Location - City or Town, State □XBurial 2 □ Cremation 3 □ Removal from State Dec. 24, 2011 Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ME Forda Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ADVANCED DOMENTIA IRAKS disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical phys the as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASO 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 TYes CEREBROVASCULAR ACCIDENT 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗆 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending I (Month, Day, Year) atural 5 Pending n 24 hours after the Funeral Director, Aft anietely filled in by the fu work?
1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 5 nd address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

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Vital

Division of

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disease, or allure. List on al	r complications that cat only one cause on each	used the death line. HTH M	0.0		ae of dying	g, such as	cardiac d	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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ant condition	ons contributing to dea				cause giv	en in Part	l.		obacco use co Yes 2 🗌 No		the cause of death?
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Certifying Medical F	Physician: To the bes Examiner: On the basis	t of my knowle	edge, death o	ccurred a	at the time	, date and	place, a	nd due to the ca	ause(s) and ma	nner as sta	ated. ause(s) and manner stated
	Nurse Practitioner: T			death occ		ne time, da				d manner as	stated.
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ss of person	who completed cause SEHGAL		_	rint)	1774	noz	E	m.0.	<u> </u>		
Day, Year)	32 Reg	istrar's Signat	1 2	Jegy.)		_				
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			ORIGIN	4AL							

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sam e ep

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 1 1 - 1 1 - 201 1 av 5:45 PM Annie Coles 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛭 F Months Days 10-07-1922 Hours 215-24-7922 89 Yrs. VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3429 Vargis Cir., Apt. 21244 U.S. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 K No Black, White, etc. 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Custodian Custodial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cleophus Hopkins Octavia Preas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Coles/Daughter-In-Law 3429 Vargis Cir., Apt. 2B/Baltimore, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Arbutus Mem. Park 11-19-2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latimore Funeral Services of Funeral Service Licens alres 2818 E. Baltimore St./Baltimore,MD 21224 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Chronic Respiratory Failure disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):

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Physician/

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Baltimore, Maryland 21215-0036

er than "natural", or items 23a on the Medical Examiner must be

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should be filed with and Mental Hygien 7 is marked other to

t. Page 1 and 2 should b trnent of Health and Mer rtant; If item 27 is mark jury or other traumatic

Department of Himportant: If ite any injury or of

traumatic event,

or Attending Physician: The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

To the Hospital

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and I-trans physician a the burialattending p ed by the has certificate this After thi funeral within 24 hours at er death.

To the Funeral Director Af
completed filled it by the fu

Examir Physician/Medical þ Completed

Be မ Certificate:

Medical

29a. Certifier

Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 XNo

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Live Birth 2 Live Birth 2 Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown

Year

24a. Was an autopsy performe Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 No

10

25. Was case referred to medical examiner?			26. Place of Death (Che	
1 ☐ Yes 2 🛣 No	Hospital:		Other:	<u> </u>
I Les Z (XIVO	1 ∐ Inpatient 2 ∐	ER/Outpatient 3	DOA 4 Nursing l	Home 5 Residence 6 X Other (Specify) Hospics
27. Manner of Death	28a. Date of injury	28b. Time of	28c. Injury at	28d. Describe how injury occurred
1 🔀 Natural 5 🗌 Pending	(Month, Day, Year)	injury	work?	Loan Booking How Highly Goodings
2 Applicant Investigation		M	1 Ves 2 No	

3 Suicide
4 Homicide 6 Could not be determined

Atrial Fibrillation

Cerebrovascular Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) signature and title of certifier 29b. 29d. Date signed (Month Dav. Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Merrield Helen Conroy December 2011 9:20A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 310 Willrich Cir. Apt. G Harford Forest Hill 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 216-56-7682 Usual Residence of Deced 1 □ M 2 💢 F 68 October 2,1943 Maryland show 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Md. Harford Forest Hill 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 310 Willrich Cir. Apt. 21050 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 🗓 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 Divorced 4 X Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Culinary Technician McCormick and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Givens Conroy Merrield Helen Kaine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Lusco DTR. 3226 Chesley Avenue Parkville, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-27-2011 Parkville, Md. Parkwood Cemetery 21. Signature of Fune | Sarvce Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home 6415 Belair Road Balto.Md. 21206 Rad 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events soulding in deeth). Due to (or as a consequence of): Examin Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending physical for use as the b IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Dav Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autons perform or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be neral Director: 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year, 30. Name and a cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December WILLIAM WALLACE 21. 2011 COTTRELL SR 1:37A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Gilchrist Center Baltimore Towson 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Min 214-16-8873 90 **1XX** M 2 □ F **Director** 08/21/1921 Maryland Usual Residence of Decedent 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1XXYes 2 □ No Maryland | None (4321 Greenhill Avenue)Baltimore o 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral 4321 Greenhill Avenue 21206 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, d Forces Black, White, etc. "natural", or by 1 Never Married 2 Married 1XXYes 2 No WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify 3 XWidowed 4 □ Divorced Specify Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Electrician Manufacturing Health and Mental Hygie tem 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Wallace E. Cottrell Minnie Mae Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Wallace Cottrell JR Son 547 Valley View Road Towson, Maryland21286 Department of Health Important If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 12/23/2011 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery nature of Funeral S 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the diseas Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final re Tulmany Discoole Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine day, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death Day g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page perform this certificate Yes 2X No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Director; Af Accident Investigation ☐ Accider 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completely filled in by determined City or Town, State 24 hours a Medical 29a. Certifier 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29c. License number 29d. Date signed (Month, Day, Year) 00071287 12-21-11 affinere, MO 21204 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 12:50 PM December <u> Aaron Roosevelt Carter</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** <u>Future Care -</u> Lochearn Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth Funeral Months Days Hours Min. (Month, Day, Year) Mary land **Director** 217-84-4736 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 W. 20th St. 21218 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced per nit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important. If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) laborer construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H ပ Roosevelt Carter Miriam Stansbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3300 Ludgate Rd; Baltimore, MD 21215 Miriam Carter - mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State rmit. Page 1 a 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state Signature of Euneral Service Licer 22. Name and Address of Facility State Anatomy Board ₩ade, Director 655 W. Baltimore St; Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause leach line. Approximate Interval Betwee Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a cons quence of): Examiner Secreptially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 20 No certificate Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 I within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 \square No Accident Suicide 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

SMITHA

2835

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W

29c. License number

PARTITIONS

29d. Date signed Month, Day, Year) 2011

2120

SULTO

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Holland Culbertson, III Harry December 7:45 2011 Medical M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 0 Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 177-22-3397 **Director** 1 X M 2 □ F 83 August 28, 1928 Pennsylvania Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery North Potomac 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 14124 Saddle River Drive 20878 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give "natural", 3 X Widowed 4 □ Divorced WWII Specify: White Year or Dates. if Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry CULBERT SON (Specify only highest grade completed) National Security Elementary/Secondary (0-12) College (1-4 or 5+) Agency Staff Chief Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Holland Culbertson, II Regina Lineham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ~20878Mark Culbertson /Son 14124 Saddle River Drive, North Potomac, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) December 24 Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun and Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Dimita for as a nonsection cause. Enter Underlying Cause (Disease or injury that initiated events burial-transi and Due to (or as a consequence resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 Ectopic pregnancy signed by the atter in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Unknown Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗱 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending within 24 hours after death. To the Funeral Director: A 1 Yes 2 No ☐ Acciden ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one tying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu 29d. Date signed (Month, Day, Year) 17002557 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #203 SILVER SPRING HESHMAT GEORGIA AVE 20902 10301 Registrar's Signa State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 20, 2011 HELEN M. **CARRADO** 7:43 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER ANNE ARUNDEL GLEN BURNIE Social Security Number 6. Sex If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-22-4973 1 □ M 2 🛣 F 84 Hours 3-1207th Per 27th Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director ms 23a or 28a-f s must be notified Glen Burnie MD Anne Arundel 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code **21061** 10g. Citizen of What Country? 7975 Crain Hwy. Apt. 201 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc Completed by 1 Never Married 2 Married 1 Yes ; 1 ☐ Yes 2 X No Specify: white 3 X Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Owner Home maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname n and Mental H မ Francis Walters Adelia (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is Bette Jane Evans/Daughter 858 Brighton Place, Glen Burnie MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 Burial 2 X Crema ion, 3 🗌 Removal from State Metro Crematory 12/21/2011 Elkridge, MD 4 Donation 5 Other (Specify 21. Signature of Fu 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 M01364 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ralismant condine Physician/ arrythm disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine Dire to (or east consequence of) If any leading to immedia cause. Enter Underlying Cause (Disease or iinjury burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 oronary Artery D. sease 1 Yes 2 No 3 Probably 4 Inknown Completed abetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy this certificate geath? 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🕅 No Other: ည 1 X Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) re Hospital or Attending Pt n 24 hours after death. re Funeral Director: After the oleted filled in by the funeral 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D33296 DECEMBER 21, 2011

State

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Registrar

31. Date filed (Month, Day, Year).

Registrar's Signature

A Aparla

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEIL E. PADGETT, MD,

7711 QUARTERFIELD RD., GLEN BURNIE, MARYLAND 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ <u>December</u> Hartman Frazier Dillingham 2011 9:21 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Woodlands Assisted Living Center Baltimore Middle River Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign North Hours (Month, Day, Year) 7/10/1933 Director 257 48 9969 Carolina Usual Residence of Decedent shov 10b. County Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 🏋 No Maryland Baltimore Essex 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 Riverside Road 21221 United States items ; 11 Marital Status 12. Was Decedent Ever in LLS. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates, 1952–56 1 Yes 2 No Specify. "natural", Specify. 3 Wldowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmet. Elementary/Seconday (0-12) College (1-4 or 5+) 11 Police Officer Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hartman Frazier Dillingham Sr Ruth White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Dillingham (wife) 24 Riverside Road Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Ind 12/27/2011 Baltimore Maryland 21. Si tule of Funeral Service Lice 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, Approximate or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Atheroscle notic Physician CCIPTIONES CUILA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? ō Month Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 ☐ Yes 2 ☐ No 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 2 No 1 🗌 Yes ျှ 1 Inpatient 2 Impatient 2 Impatient 3 Impa Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🜠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٩ 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) Sares Sales Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Davenport Physician/ 12:39 DM Wortham 2011 20 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Shock Trauma HUSDITA If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Director 096-28-1643 1 🛛 M 2 🗆 F 76 Yrs Dec.14,1935 Venezuela Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 1 Yes 2XX No MD Howard Laurel 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? be Funeral 23a 8208 Cool Creek IISA 20723 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. "natural", or ite Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Certified Safety Engineer Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Lovelace Wortham Davenport 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Carol A. Davenport/ Wife 8208 Cool Creek, Laurel, MD 20723 Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Dec 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crem. Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. Signature of Funeral Service Licensee KerSVile M01053 313 Talbott Ave., Laurel, MD 20707 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final MematomA Physicum/ Subduna disease or condition Medical resulting in death) Due to (or as a consequence of) CarolHallann Examiner a1 Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No ed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Heunt dixax 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an burs after death. eral Director. After this certificate has I filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical exampler?
1 ☑ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year)

November 20,201

28b. Time of injury wor 1

28c. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Accident 5 Pendina work?
1 \sum Yes 2 \sum No tripped over Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number determined State) Cree K Home Maryland Laure 8208 Cool 24 hours a Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 1568680980 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer Gutwald MD, 22 s ,22 South Greene St., Baltimore, MD 21201

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nettie Dora Decker Physician/ December 22, 2011 01:05 Ам Medical 4a. Facility Name (if not institution, give street and number)
William Hill Manor 4b. City, Town, or Location of Death Easton **Examiner** 4c. County of Death Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Numbe 226-09-1567 **Funeral** 1 □ M 2 **X** F Months Days Hours Min 94 08/10/191 Yrs **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Talbot Wye Mills 1 Yes 2 No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 21679 Funeral 12379 Mill Creek Lane items should be filed within 72 hours after death and Mental Hygiene.
is marked other than "natural", or items aumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Hospitality Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Oscar Neighbors permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Katherine Harrelson Annie 19a. Informant's Name/Relationship (Type, Print)
Mary Ann Stephenson / Daughter 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12379 MIII Creek Lane, Wye MIIIS, MD 21679 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State cemetery, crematory or other place) 12/24/2011 4 Donation 5 Utrier (Occasion)

Signature of Funeral Service Licensed Orota 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 22. Name and Address of Facility Por Box 1413, Baitimore, MBS 21203 Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ U ROSEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or ithat initiated events -tran and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year detached 9 Unknown P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, EN CEDITO DATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of page 2 has autopsy performe death? certificate Yes To the Hospital or Attending Physician: 25. Was case referred to medical æ examiner? 2 X No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this ...anner of Dea 1 Natural 2 Accident 3 Suicid funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, de eath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month, Day, Year) ATTENDING MD State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ DOZIER DECEMBER DECEMBER L. WALTER 6:38AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7010 ONYX COURT CAPITOL HEIGHTS PRINCE GEORGE'S Social Security Number **Funeral** . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours DEC. 24 1950 CHICAGO, ILL **Director** 355-44-6761 60 Usual Residence of Decedent 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27.5 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County 10d. Inside City Limits Director MD PRINCE GEORGE'S CAPITOL HEIGHTS 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7010 ONYX COURT 20743 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK 3 🗌 Widowed 4 🗌 Divorced If Yes, Give Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ DIRECTOR OF INFORMATION PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ LEE DOZIER MILDRED E. FREENEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILDRED DOZIER/MOTHER 9646 SOUTH CALUMET AVENUE CHICAGO, ILL 60628 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State ST. MARY'S CEMETERY 12/29/11 CHICAGO, ILLINOIS 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate cause (Final disease or condit in resulting in death) Onset and Death Physician/ MULTIPLE MEYLOMA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy performed? Yes 2 K No death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 1 🗌 Yes 1 ☐ Yes 2 ☒ No or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 XYes 2 🗆 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 1 X Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 🗌 Homicide determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check

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State Registrar

29b. Signature and title of certifie

VICTOR M.

31. Date filed (Month

30. Name and address of person was completed cause of death (Item 23a) (Type, Print)

PREIGO M.D.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D23308

6420 ROCKLEDGE DRIVE #4100 BETHESDA, MARYLAND 20817

29d. Date signed (Month, Day, Year)

DECEMBER 23, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 12:35 P M Joseph Albert Dowling December 2011 S Medical 3 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville N Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Hours Min 076-18-6977 **Director** 1 **X** M 2 □ F 85 Nov 10, 1926 Scotland Usual Residence of Deced 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Numbe ò 10g. Citizen of What Country? must be Funeral with 23a 14508 Homecrest Road 20906 United States items ? 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian rmed Forces?

X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 'natural", or 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates.1945–1946 3 X Widowed 4 Divorced Caucasian Completed ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) DOWLING 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Professor Education marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Joseph Dowling, II Maude Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> permit. Page 1 and 2 sh
Department of Health at
Important; If item 27 is
any injury or other trau Kathryn Dowling Borten/Daughter 131 Selby St. Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State OSEPH Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 12/27/2011 Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21. Signature of Funeral Service Li MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CARDIO PUL MONARY disease or condition resulting in death) ARREST Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION Sequentially list conditions Examine During for as a donsequings of: if any, leading to trained cause. Enter Underlying Cause (Disease or injury PLEURAL RECURRENT use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be exect thours after death.

Funeral Director: After this certificate has been signed by the attending physician ar physician by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 1 L Yes 2 L 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be SEVERE PULMONARY HYPERTENSION TRICUSPID REGURGITAT Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed PNEUMONIA HYPERTENSION, ANEMIA LOWER EXTRÉMITY DEEP VEIN THROMBOSIS TON, PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 HISTORY OF CEREBROVASCULAR ACCIDENT, SEVERE ADRIC STENOSIS 1 ☐ Yes 2 🕱 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 X Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical within 24 hou

To the Funer

completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar In and

MOHAMMAD

MEHMOOD D.O. 9901 MEDICAL CENTER DRIVE

H72163

12/22/2011

MD 20850

ROCKVILLE

0-0-

32 Registrar Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Richard V. Delabre Jr. Physician/ ₩[™]2 / 14 / 2 011 12:26pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12328 Pulaski Hwy Apt 5 Joppa Harford cial Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Unde 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 351-40-6534 Days Months Hours 04/01/1949 Director 1 🖾 M 2 🗆 F 62 IL Usual Residence of Dece show items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10a Sta MD 10d. Inside City Limits Director Harford Joppa 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 12328 Pulaski Hwy Apt 5 21087 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medicial Examines. 14 Race - American Indian Black, White, etc 1 X Never Married 2 Married ò 1X Yes 2□No If Yes, Give Vietnam Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾No Specify: White Completed 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
iite. Do NOT use retired)
Photo Lab Tech 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Photography Be 17. Father's Name (First, Middle, Last)
Richard V. Delabre Sr 18. Mother's Name (First, Middle, Maiden Surname) 2 Theresa Ann Marlaire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Richard Delabre Sr Father 472 South Forest Ave Bradley IL 60915 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crem 12/24/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of F meral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physicin/ heone 00 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami burial-transi or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month signed by the at d be detached for Pregnant at time of death Dav Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed Should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 1 🗆 Yes 2 🗆 No Yes 2/1X/No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA hours after death. uneral Director: After this 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending injury Accident Investigation Suicide 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral I To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 201

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who

RUD

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oleted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) (AKA) Edward Dwojewski 2. Date of Death Physician/ Month December 02:00 A-M **EDWARD** DORSEY 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice @ Northwest Hospital Baltimore County Randallstown Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 195-12-9015 **Director** 1 🗶 M 2 🗌 F 88 Aug 15, 1923 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified N/A Maryland 1 X Yes 2 No Baltimore 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 3218 Cedarhurst Road 21214 USA items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ed Forces? Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates. '44-'46 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Production Worker Areospace Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ John Dwojewski Victoria Koszan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Connolly (Daughter) 10069 Green Clover Dr., Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ¥Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Spacify) 12/29/2011 Baltimore, Maryland 21. Signatur / Empra volumento www. MTTCHELL WIEDEFELD FUNERAL HOME, 6500 York Road, Baltimore, Maryl HOME, INC. Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Physician/ ver disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Tigury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran signed by the attending physician and dbe detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Nown MITTEL THIS CERTIFICATE HAS BEEN SI funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{No} \) Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) In Pt Hospita Hospital: ၉ within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Accider
Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year

State Registrar

31. Date filed (Month, Day, DHMH 17 Rev 06-2011

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6974 Muidea Chaice Lane 21061

December 25, 2011

11-09077 Mark Drummond

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				tificate of Death	Reg. No. 2011 4128							
	hysici Exam		Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year Decomber 2 2011 1100 hrs							
uicai	LAdili	IIIIGI	Mark Drummond 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	December 2, 2011							
			21262 Joebaker Court	Lexington Park	St. Mary's							
	uneral rector		5. Social Security Number 6. Sex 7. Age (In yrs. la 063-54-0067 1 M 2 F 55	st birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	Familian							
			Usual Residence of Decedent									
	эж апу			Town or Location	10d. Inside City Limits 1 Yes 2 X No							
ryland	a-f sho	Director	MD St. Mary's Le	exington Park	10g. Citizen of What Country?							
15-0036 filed within 72 hours after death with the Maryland	or items 23a or 28a-f show must be notified at once.	l Dire	21262 Joebaker Ct.	20653	USA							
eath wit	items 2 ust be r	Funeral	11. Marital Status UNK 1 Never Married 2 Married Armed Forces? UNK 1 Yes 2 No	S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto								
after de		by F.	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify: White							
hours	'natur Exami	t pet	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a, Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use retired.)	vork done UN k 16b. Kind of Business/Industry UN k red)							
336 thin 72	than edical	Completed	unk unk									
215-0036 be filed within 7	Hygier I other the M		17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maiden Surname)							
2121	Mental marked c event,	o Be	Mark R. Drummond 19a. Informant's Name/Relationship (Type, Print)		Laras Rural Route Number, City or Town, State, Zip Code)							
5 sh	h and l 27 is r imatic	-	O.C.M.E.		; Baltimore, MD 21223							
5 - g	# 5 b			Place of Disposition (Name of cemetery, rematory or other place)	Date 20c. Location - City or Town, State							
Baltimore, permit. Pages I a	Department of Important: I		4 Donation 5 House specing in state Bri	Insfield Echols 1-3	-2012 Charlotte Hall, Md.							
Bal	Depar Impo injur		21. Signature of Funeral Service Vicensee, Rosmall S. Wade, Director	Brinsfield Funeral	Home 22955 Hollywood Rd. Leonardtown Md 70650 respiratory arrest, shock, or heart							
	sician		Sa. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac o	r respiratory arrest, shock, of heart Approximate Interval Between Onset and							
	edical miner		Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal Hemorr		Death							
			Sequentially list conditions, b. Chronic Alcoholism									
		iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Cliesces in invitated C.									
ited	d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
, se execu	g physician and s the burial - transit	Medical	UNPENDED X AMENDED 5,9,17,1	18,20a-c,22 per fh g924	2-6-12 vt							
3760 ficate b	g physi s the bu		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregn	nancy 2 Fetal death 3 Ectopic pregna	23d. Date of delivery Incy Month Day Year							
X 60	the attending ned for use as t	hysician/	past 12 months?	2								
D. Bo	by the a	Phys	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?							
P.C	signed be deta	d by			1 Yes 2 No 3 Probably 4 Unknown							
ords v requi	has been s	olete			24a. Was an 24b. Were autopsy findings available prior to completion of cause of							
Reco	cate ha page 2	Completed			performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No							
ital ician:	his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	26.Place of Death (Check of ER/Outpatient 3 DOA Other Nursin	only one) g Home 5 Residence 6 🗸 Other: Scene							
of V	After this certificate has been signed funeral director, page 2 should be deta	ı: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred							
sion ttendi	death.	cation:	Pending Accident Investigation	1 Yes 2 No								
Divisital or A	iours after d neral Direct filled in by	Certific	3 Suicide 6 Could not be determined (Specify)	me, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed	within 24 ho To the Fune completely fi	cal	29a. Certifier 1 Certifying Physician: To the best of my knowledg one) 2 Medical Examiner: On the basis of examination an									
L _C	.w 5 00	Medi	and manner stated. 29b Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							
			() interleur)	O.C.M.E.	December 3, 2011							
			30. Name and address of person who completed cause of death (Item Laron Locke MD. Assistant Medical Examiner	^{23a)} 900 W. Baltimore Street, Baltimore, M	MD 21223							
	S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signatur									

DHMH 17 Rev 1/2001

ORIGINAL

11-09111 James Douglas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #9 State of Maryland Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day December 3, 2011 1942 hrs Medical Examiner James Douglas 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or - 111TK 5. Social Security Number 1177 1 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign North Months Days Hours Min. Country) Carolina Director April 26, 1952 59 1X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County MD 1 X Yes 2 No Baltimore 28a-f shov permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23s or 23s-f sho injury or other traumatic event, the Medical Examiner must be notified as once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 400 W. Lexington St. 21201 USA 12. Was Decedent Ever in U.S. Funeral 14. Race - American Indian, Black, 11 Marital Status 1171 K 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces?-un If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 XX Married XX No Yes specify: black If Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 100 Hz. 16b. Kind of Business/Industry 100 K 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 unk unk Laborer 18.Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) UNK Be 19a. Informant's Name/Relationship (Type, Print)

KIMAH JOHNSON stepdaughter dress (Street and Number or Rural Route Number, City or Town Harpers Farm Rd - Columbia , MD ဂ္ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 21. Simultare of Funeral Pervice Licen 22. Name and Address of Facility State Anatomy Board Wade, Director 655 W. Baltimore St; Baltimore, Maryland 21201 Approximate Interval complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Pailure. List only one cause on each line Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **≵xaminer** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any leading to immediate cause. Enter Underlying Cause Due to (or as a conse juence of):

В Physician/Medical signed by the attending physician be detached for use as the burial 2 Completed has been certificate page Be this After cation

Director:

within 24 h To the Fur

ţ

Medical

2

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

(Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last X UNPENDED AMENDED23a, 27, per me, g922 12-28-11 sm IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes

2 No 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 1 X Natural Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.

30. Name and address of person who completed cause of death (Item 23a)

(Specify)

and manner stated.

6 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifie

Pamela E. Southall, MD 31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

23d Date of delivery 3 Ectopic pregnancy Month Day

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one)

Other Nursing Home 5 Residence 6 Other 28d. Describe how injury осситеd

28f. Location (Street and Number or Rural Route Number, City

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) December 4, 2011

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 No

ORIGINAL

Fetal death

Other (Specify)

5

28b. Time of Injury

DHMH 17 Rev 1/2001

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar		artment of rtificate o		F	Reg. No. U	1 41284	
144	Physic /Medi	cai	1. Decedent's Name (First, Middle, L	DALTON		Ab Cib. Total	, or Location of De	2. Date of Dea	Day		
7	Examir	ner	Good Samaritan				imore	rau i	4c. County of	Deali	
道	Funeral Director		5. Social Security Number 6. 219-60-7955 Usual Residence of Decedent	Sex 7. Age (In yrs. 1 M M 2 □ F 57	(ast birthday) Yrs.	If Under 1 Yea Months Day		8. Date of Birth in. (Month, Day Oct 3,	Year) 1954	9. Birthplace (State or Foreign Country) Maryland	
	a-f ehow	ctor	10a. State 10b. County MD Balti		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	h with th	al Dire	10e. Street and Number 8504 Chestnut	Oak Rd.		10f. Zip Code 2123			10g. Citizen of Wh USA	nat Country?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel" or Items 23s or 28s-f show any injury or other treumatic event, the Medical Examinational be notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates:		Was Decedent of Yes, specify Cu	ıban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black	- American Indian, , White, etc. black	
Maryland 21215-0036	ithin 72 ho ie. ian "natur i Madical	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	_	upation ne during most of vired)	vorking	16b. Kind of Bus		
nd 21	e filed will Hygien I other th	Be Con	12 17. Father's Name (First, Middle, Las	0 unk	che	ef		łame (First, Middle,	Maiden Sumame,	Industry	
<u> </u>	Jould by Menta	To		T		Barbara McCo					
, Ma	and 2 shalth and n 27 is n		19a. Informant's Name/Relationship Dawn Dalton —	daughter	850	4 Chest		Rural Route Numbe Rd; Parkv			
Baltimore,	Pages 1 ment of He ant: If Item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Spec	☐Removal from State	Place of Dispo cemetery, crer	sition (Name of matory or other p	lace)	Date	20c. Location - C	ity or Town, State	
Bait	permit. Depertinont import any injustinos.		21. Si lature of Funeral Service Lice Ronald	Wade, Directo	r 22			tate Anat e St; Bal	-		
F ₂ C	Physician		23a Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the deat yone cause on each line.	h. Do not ent	er the mode of d	ying, such as card	iac or respiratory ar	rest,	Approximate Interval Between Onset and Death	
8760,	physicien and physicien and strength and physicien and strength and st	dical Examiner	Sequentially list conditions, I any, leading to mini cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
O. Box 6	death certif e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3□	Ectopic pregnar Other (specify)			23d. Date Mont	of delivery h Day Year	
rds, P	ires tha signed d be de	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause (given in Part I,			oute to the cause of death?	
r	The ate h pege	Completed						24a. Was a autop perfor	sy pri med2 de	ere autopsy findings available for to completion of cause of tath? Yes 2 \[\] No	
VItal		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ₽	ER/Outpatien	1 30 DOA)than	eath Check only or		(Specify)	
	ding h. After fune	atlon; T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	11 3 DOX 4 14d Sing Home 3			Describe how injury occurred			
=	를 다 들	Certification;	3 ☐ Suicide 6 ☐ Could not lead to determine determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, offic	е	28f. Location (S City or Tow		r or Rural Route Number,	
	호근 필운	edical	29a. Certifier (Check only one)	hysician: To the best of my knominer. On the basis of examination and manner stated.	wiedge, death	occurred at the vestigation, in my	time, date and play opinion, death or	ice, and due to the courred at the time, o	cause(s) and mani date and place, an	ner as stated. nd due to the cause(s)	
)	To the I	Me	29b. Signature and title of certifier	a er.D.		29c. Lice	nse number 90182	30	29d. Date signed	(Month, Day, Year)	
			30. Name and address of person who	SHASHLDAA.	RAN.	Print)	Saman	itan Ho	julal.	m 13,2011	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 7 201	32. Registrar's Signe	ature for	the !			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0610 AM 201 Marie Dauses Janice December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnus n/a 8. Date of Birth (Month, Day, Year) **March** 23, 1947 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 XF Months Maryland Director 214-50-6512 64 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore n/a 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Unit 220 21227 USA 200 1st Avenue 11. Marital Status 12. Was Decedent Eyer in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: "natural", Specify. 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Αt Home 12 Homemaker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Norma Mae Monroe Franklin Ford Whitmer ige 1 and 2 should be nt of Health and Mer t: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 College Parkway Annapolis, Maryland 21409 Rev. Jeffrey Dauses (Son) other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Department o Important: If any injury or ò Hilltop Service Corp. 12/27/2011 Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) of un al Servic 21204 21. Signature 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph si i n PD + Xacussation disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exami that the death certificate be executed and tran Due to (or as a consequence of): resulting in death) Last y physician al Is the burial-t Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 U signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to predical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28c. Injury at 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred Accident (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my Incidence death. 31 at the time, date and place, and don't a the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) AYY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nue Baltimore, MD 31. Date filed (Month Pay. State

DHMH 17 Rev 7/2009

Registrar

भ्याप्त

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 23, 2011 2:43 AM December Physician/ Determan, Sr. James Henry Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Towson Gilchrist Birthplace (State or Foreign Country) 8. Date of Birth If Under Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Social Security Number Funeral (Month, Day, Year) Days Hours 214-28-7033 1 🕅 M 2 □ F Dec. 6, 1931 Director Maryland 80 Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a, State **Funeral Director** 1 Yes 2 X No Timonium Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21093 2525 Pot Spring Road K407 item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Arged Forces? 1 2 Yes 2 2 No Black, White, etc Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education during most of working (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) d Mental Hygiene. marked other than Flementary/Secondary (0-12) Westinghouse Electricial Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Noon Marguerite ပ Mary Determan В. John and 2 should b Health and Mei tem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type, Print) Timonium, Maryland 2525 Pot Spring Road K407 Nancy C. Determan 20c. Location - City or Town, State 20a. Method of Disposition
1 🛣 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Diffaffey envia 1 Tether place)
Memorial Gardens Department of F
Important: If ite
any injury or ot
once. Timonium Maryland 12-27-2011 ☐ Donation 5 ☐ Other (Specify) Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 22. Name and Address of Facility time of Eurieral Service Licensee Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rementia ravs Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): death certificate be executed sician and e burial-trans Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 ves, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy

Sessent at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Dav g Unknown the Hospital or Attending Physician: The law requires that the Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: hosp(a 4 Nursing Home 5 Residence 6 Other (Specify 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at Certificate: Natural work?
1 Yes 2 No 5 Pendina Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Funel completely fi only one) 29b. Signature and title of certifie December 23 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST TOWSON MA hones JXI 6701 N-M) HARVES

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 20^{rear} Margaret Marie Edwards 1910 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country) Georgia Days 577-44-1452 1 | M 2X | F Director 04/25/1932 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** must be notified DC: Yes 2 No Washington 10f. Zip Code 10g. Citizen of What Country? ò 23a 225 Quackenbos Street, NW 20011 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black If Yes Give 3 XWidowed 4 ☐ Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK should be file and Mental F is marked of ပ Annie Belle Keitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Cheryl Y. Edwards (Daughter) 225 Quackenbos Street, NW, Washington DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 12/29/2011 Suitland, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Livense 22. Name and Address of Facility Latimore Funeral Services, PA 2818 E. Baltimore_Street, Baltimore MD 21224 23a. Part 1. Enter the disease, properties on the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death mmediate Cause (Final ASPIRATION Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury DISORDER Exami the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last ARRHYTHMIA Physician/Medical Box 68760 IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death completed filled in by the funeral director, page 2 should be detached P.O. ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RESPIRATORY Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed ANEMIA 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy MALNUTRITION performed? 2 No 2. No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Kinpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director, After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending **X** Natural work? 1 \(\sum \) Yes 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Kayat-MD Chandy eller MD52855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7207HANOVE R CHANDRASEKHAZ KORAPATI.MD GREENBELT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 1255 PM 01 Medical Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Medicat HIMORE r 1 Year If Under 24 Hrs. ocial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 X M 2 🗆 F Months Davs Hours Min. Country) Yrs 90 Director 20 Marvland 212-12-1293 Jul Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland aţ 10c. City, Town or Location Director other traumatic event, the Medical Examiner must be notified 1 Yes 2 No MD Baltimore Baltimore 9 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4102 Taylor Ave. Apt 329 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ★ Yes 2 □ No
If Yes, Give Black, White, etc. other than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced If Yes, Give Year or Dates. WWIT Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Automotive Sales Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H is marked မ Harry J. Elder Sr Laura Hull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Patrick Elder /Son 43 Passage Way Terr. Gerrardstown, WV 25420 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Dec 2 injury or Beltsville, Maryland 4 Donation 5 Other (Specify) 2011 <u>Chesapeake Crematory</u> of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives any 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Valcular demention disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ending physician and use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Exal Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death signed by the a d be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 🗌 No 3 Probably 4 V Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? has page 2 2 🗌 No 1 Yes Yes of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c, License number n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 10 North GREENE St. Baltinore, MD 2601 32. Registrar's State

DHMH 17 Rev 7/2009

Registrar

1-03433	Please Type of Print in Black Indelible Ink. Ensure All Copies Are L	.eaible.			
Rodney Deron Edwards	State of Maryland / Department of Health and Mental Hygiene		2011	4	120
1- For State Registrar	Certificate of Death	Rea No	2011	4	1 4 3

		1- For State Registrar	ile oa.y.a.re	Ce	ertificate d			ia mon	.c.i i i y g		g. No.	11 4129
Physicia Medical Examin	n/	 Decedent's Name (First, Middle, 	A11*							Date of Death	1	3. Time of Death
Wedical Examin	ler	RODNEY DE:	B11.	DWAR	DS	4h City	Town	r Location o		Month December	18, 2011 4c. County of Do	0017 hrs
		Prince Georges Hospita		,			verly	Location	Deau		Prince Geo	
Funeral		5. Social Security Number 6	5. Sex 7. A	ge (In yrs.	last birthday)	If Un	ider 1 Yea	ar If Unde	r 24Hrs.	8. Date of Birth	h(MM/DD/YYYY) 9.	Birthplace (State or
Director	-	577-02-2706	1 X M 2 F		35 y	Mont	ths Day	ys Hours	Min.	03/01/	1976 F°	reign Country) DC
	ı	Usual Residence of Decedent										
w any		10a. State 10b. County	anonenia		, Town or Loca	ation						10d. Inside City Limits
daryland 28a-f show Lat once.	ឆ្ក	MARYLAND PRINCE 10e. Street and Number	E GEORGE'S	LA	ANDOVER	1 404 7						1 X Yes 2 No
e Mar or 28	Director	7746 NORMANDY RO	$\Omega \Lambda D$			101. 21	ip Code	785			g. Citizen of What C	•
s 23	ᇎ	11. Marital Status	12. Was Deceder	t Ever in l	J.S. 13. W	las Deced			in2 (Spec	ify Yes or No-	UNITED ST	ATES nerican Indian, Black,
death r item	Fune	1 Never Married 2 Marr	ied Armed Forces					n, Mexican,			White, etc	
E . E		_	ced If Yes, Give Year		1	Yes 2	2 <u>X</u> No	specify:			Specify: B	LACK
hours natur Exam	Completed by	15. Decedent's Education (Specification)	y only highest grade co		16a. Decede			tion (Give k			16b. Kind of Busine	ss/Industry
36 in 72 in 72 fam "	E	Elementary/Secondary (0-12) 10TH	College (1-4 or	5+)						ĺ	DDTUADE	
d with	탉	17. Father's Name (First, Middle, La	ast)		PORT	EK	I	18.Mother's	Name (F	irst Middle Ma	PRIVATE aiden Surname)	
21215-0036 Mental Hygiene. marked other than "natural revent, the Medical Examin	8	SQUARE H.	BYNUM,	I	II			JULIA			EDWARDS	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than 1 unaite event, the Medica	의	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addres	s (Stree	et and Numb	per or Rura	al Route Numb	er, City or Town, St	ate, Zip Code)
S =	Ţ	JULIA WILLIAMS , 20a. Method of Disposition	/ MOTHER	100								LAND 20785
= s % = s		1 X Burial 2 Cremation	3 Removal from S	ate	Place of Dispo crematory or o	ther place	9)				20c. Location - City	•
timent transfer	4	4 Donation 5 Other Spec		RE								MARYLAND
Baltimo permit. Page Department of Important: injury or oth	1	21. Signature of Funeral Service Lic	nensee									HOME, INC.
Physician	1	23a. Part I. Enter the disease, or co	mplications that caused	the ath	. Do not enter	the mode	of dying,	Such as car	JAD, rdiac or re	Spiratory arres	VILLE, MA	RYLAND 20785 Approximate Interval
/Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Gunshot Wounds									Between Onset and Death	
Examiner	-	or condition resulting in death)	Due to (or as a cons									
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ted nrsit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	equence o	of):							
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760, icate be execuply by sician and the burial - tra		F FEMALE:	23c. If yes, outco	no of area		_					1001 71 111	
587 rrifica fing ph		3b. Was decedent pregnant in the past 12 months?	1 Live birth	ne or preg	,	etal death	3 [Ectopic p	oregnancy		23d. Date of deliv Month	ery Day Year
Box 687 death certification the attending and for use as the street of	5	1 Yes 2 No 9 Unkno	wn a Pregnant a	time of de	ath	ther (Spe	ecify)					
D. Box 68: t the death certification by the attending ached for use as I	Ē	Part II. Other significant condition	9 OUKNOWN	hut not r	esulting in the	underlying	o cause o	riven in Part		23e Did tobs	acco use contributo	to the cause of death?
ires that the signed by libe detact	3	•			oouning in this	uriconymi	g oudse g	giveri ii ii ait			2 ✓ No 3 ☐ Pi	
of Vital Records, og Physician: The law require ther this certificate has been si, neral director, page 2 should b.						·			- !	24a. Was an		autopsy findings available
COI e law e has ge 2 st										autopsy perform	ed? death	
Vital Recysician: The his certificate director, page		25. Was case referred to medical					26 Place	of Death (C	heck only	1 Yes 2	No 1 ✓	Yes 2 No
f Vital Physician or this cert al directo		examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 🗸	ER/Outpatient			Other	Nursing H		esidence 6 Oth	ner:
ing Ph After 1 uneral		7. Manner of Death	28a. Date of Inju (Month, Day) Dec 17, 2011	ry ear)	28b. Time of	Injury		ry at Work?	leu	d. Describe how	w injury occurred	
sion ttend death. ctor: y the f		1 Natural 5 Pending 2 Accident Investiga			2200 hrs		1 Y	res 2 🗸 N	lo Sui	ojeći snoi i	by law enforcer	nent
Division o spiral or Attending hours after death. meral Director: After filled in by the function: Certification:		3 Suicide 6 Could no				et, factory	, office b	uilding, etc.	28f	. Location (Street or Town, State	eet and Number or F	Rural Route Number, City
Ospita hours uneral		4 Homicide determing the determination of the deter	(Openin) Oli							0 Blk, Green	nléaf Avenue, Lan	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Tuneral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Re Completed by Dhysician Medical Ex	5	Check only colding in ity a	ician: To the best of mer:On the basis of exa	/ knowledo nination a	ge, death occui nd/or investiga	rred at the tion, in my	e time, da y opinion,	ite and place , death occu	e, and due irred at the	to the cause(setime, date an	s) and manner as st d place, and due to	ated. the cause(s)
To ros	2	9b. Signature and title of certifier	and manner stated.				c. License				29d. Date signed (N	
		1/1/1	1/1/				79.C.N	M.E.		1.	December 18,	
	3	0. Name and address of person who	o completed cause of d	eath (Hum	23a) /	/4/	(
		Russell Alexander MD.	Assistant Medic			W. Balt	timore	Street, B	altimore	e, MD 2122	23	
State Registra	_	1. Date filed (Month, Day, Year)	2011 32. R gistra		1. A.	ender					no WE	

April Renee Edmo	j	1- For State Contificate Registrar Certificate		itai riygiene	Reg. No. 20	1 4129
Physician Medical Examin		Decedent's Name (First, Middle,Last) APRIL RENEE EDMONDS-JONTOW		2. Date of D Month Decemb	Day Year Day Year Der 23, 2011	3. Time of Death 1926 hrs
)	ľ	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location		4c. County of Deatl	1
Funeral	4	18136 Windsor Hill Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Olney If Under 1 Year If Und	ler 24Hrs. 8. Date of	Montgomery Birth (MM/DD/YYYY) 9. Bir	tholace (State or
Director		E70 06 066E F	Months Days Hours	s Min	Foreig	
A O Y		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo.	cation		"	10d. Inside City Limits
E	اة	MD MONTGOMERY OLNEY				1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Opparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho limportant or other traumatte event, the Medical Examiner must be onlifted at once.	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	ntry?
vith the	틸	18136 WINDSOR HILL DRIVE 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20832 Was Decedent of Hispanic Ori	igin? / Specify Ves or	USA	ican Indian, Black,
death w	Funeral		f Yes, specify Cuban, Mexicar		White, etc.	icali ilidiali, biack,
hours after "uatural", c	<u>ا</u> ھ		Yes 2 X No specify			WHITE
72 hour 12 hour 14 Exan	Completed		lent's Usual Occupation (Give most of working life. DO NOT		16b. Kind of Business/	Industry
21215-0036 Uld be filed within 72 Mental Hygiene. marked other than 9	Ē		KKEEPER		FOODLINE	CORP.
al Hygi	Se C	17. Father's Name (First, Middle, Last) PAUL MATHER	18.Mothe	r's Name (First, Middle ME'	e, Maiden Surname)	MELLEN
2121 ould be fi d Mental I marked			ing Address (Street and Nur		Number, City or Town, State	
MD and 2 sho alth and m 27 is munati	Ĺ		8 GUILFORD LA			
MOFe, Pages l an nent of He. not: If ite		1 X Burial 2 Cremation 3 X Removal from State crematory or		Date	20c. Location - City or	
Baltimo permit. Page Department Important: Injury or otl	+	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	CEMETERY . Name and Address of Facilit		1 WASHINGTON	
Dep Dep I I I I I I I I I I I I I I I I I I I		Hat	8900 REISTERS	TOWN ROAD.	NSON & BROS. PIKESVILLE,	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	r the mode of dying, such as o	cardiac or respiratory	arrest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Narcotic (Methadone) Due to (or as a consequence of):) Intoxication	n		Death
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	Ę١	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
To B Title	Ĕ	events resulting in death) Last Due to (or as a consequence of):				0.
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760, icate by physic the but		IF FEMALE: 23b. Was decedent pregnant in the			23d. Date of deliver	/
x 68 h certif tending use as	Clan	past 12 months? 4 Pregnant at time of death 5	Fetal death 3Ectopi Other (Specify)	c pregnancy	Month I	Day Year
Bo he deat	چ	1 Yes 2 No 9 V Unknown 9 Unknown				
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rds, require require been si hould b	<u>e</u>			24a. Wa		topsy findings available
eco he law ate has	Completed				rformed? death?	completion of cause of
ine: T	ے او	25. Was case referred to medical examiner?	26.Place of Death		3 2 NO 1 NO 10	2 110
Division of Vital Records, P.O. Box 68760, tal or Attendiog Physiciae: The law requires that the death certificate be execut as after death. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transitional actions and the state of the burial - transitional actions are as the burial - transitional actions are as the burial - transitional actions.	익	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of			Residence 6 🗸 Othe	: Scene
Sion o ttendiog death. ctor: Aft		1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 😿	. ! .	oe how injury occurred	
Division of Vous of Attending Photal or Attending Phous after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st			n (Street and Number or Ru	ral Route Number, City
ig of Fig.	5 3 -	4 Homicide determined (Specify) Residence		Olney,		
the Ho	io I	293. Certifying Physician: To the best of my knowledge, death oc one) 2 Medical Examiner: On the basis of examination and/or investi	curred at the time, date and pla	ace, and due to the ca	ause(s) and manner as stat	ed.

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

30. Name end address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

COME

29d. Date signed (Month, Day, Year)

December 24, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

inda Flower		State of Maryland / Department 1- For State Certifical Registrar	ate of Death	Reg. No.	111 4129
Physici Medical Exam	ian/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year December 22, 2011	3. Time of Death 0426 hrs
)		4a. Facility Name (if not institution, give street and number) 1129 Shady Drive	4b. City, Town, or Location of Death Edgewood		Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 213-52-2727 1 M 2 F 63	hday) If Under 1 Year If Under 24Hr. Months Days Hours Mir	` 1 ₁	Birthplace (State or Foreign Country) MD
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of MD Harford Edgewood			10d. Inside City Limits
Maryland 28a-f show d at once,	Director	10e. Street and Number	10f, Zip Code	10g. Citizen of Wha	1 Yes 2 No
th with the Maryland tems 23a or 28a-f sho it be notified at once		11.29 Shady Dr. 11. Marital Status , 12. Was Decedent Ever in U.S.	21040 13. Was Decedent of Hispanic Origin? (\$		American Indian, Black,
r dea mrit	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced or Dates:	If Yes, specify Cuban, Mexican, Puerto		etc.
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. it: If item 27 is marked nither than "natural", nr items 23a or 28a-f sho other fraumatic event, the Medical Examiner must be notified at once	Completed b	Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		
MD 21215-0036 of 2 should be filed within 7 and Mental Byggiene. In 27 is marked other than unantic event, the Medical	Be Comp	12 Ho 17. Father's Name (First, Middle, Last) James Carullo	ome Maker 18.Mother's Name Joseph	e (First, Middle, Maiden Surname)	Unk
ID 212 should be and Ment 7 is mark			o. Mailing Address (Street and Number or	Rural Route Number, City or Town,	, State, Zip Code)
re, F s l and f Healt ff item er tra		20a. Method of Disposition 20b. Place of	129 Shady Dr. Edd of Disposition (Name of cemetery, pry or other place)	Date 20c. Location - C	City or Town, State
Baltimore, permit. Pages I as Department of He Impurtant: If ite injury ar other tr		21. Signature of Funeral Service Licensee	22. Name and Address of Facility CAFA	A/Stephen D.Lo	ohrmann P.A.
Physician Wedical	- 1	23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Card	t enter the mode of dying, such as cardiac of	tures Dr. Balt or respiratory arrest, shock, or heart	t Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):	IIOVASCUIAI DISCASC		
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lox 687 eath certifics e attending p	cian/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	=		Day Y ear
, P.O. Erres that the disigned by the	þ	Part II. Other significant conditions contributing to death but not resulting Diabetes Mellitus, Congestive Hea		23e. Did tobacco use contribu	
Vital Records, bystelan: The law require this certificate has been si I director, page 2 should b	Completed			autopsy prio	ere autopsy findings available or to completion of cause of ath? Yes 2 No
ital Recitions: The section, page	Be	25. Was case referred to medical examiner? Hospital: Inputient 2 FR/Quit	26.Place of Death (Check	only one)	
n of Vi ding Physi After this funeral dir	욘	1	stpatient 3 DOA Other Nursin	ng Home 5 Residence 6 28d. Describe how injury occurred	
Division pital or Attendi ours after death. teral Director: /	Certification:	Pending Accident Investigation Suicide 6 Could not be determined (Specific)	1 Yes 2 No	28f. Location (Street and Number or Town, State)	or Rural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical Ce	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in:			
W. 17	Me	29b. Signature and title of certifier	29c License number O.C.M.E.	29d. Date signed December 24	1 (Month, Day, Year) 4, 2011
5 persu	Ì	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900) W. Baltimore Street, Baltimore,	, MD 21223	
St Regist	ate	31. Date flar Mogth Day Your Sun 32. Registrary Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 10:40^{P™} Sophie M. Fimowicz 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 2902 Glendale Avenue Baltimore 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days May 12, Year) 921 1 □ M 2 🂢 F Johnstown, PA Director 216-16-2361 90 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho ury or orher traumatic event, the Medical Examiner must be notified at ury or orher traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2902 Glendale Avenue 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Western Electric Elementary/Seconday (0-12) College (1-4 or 5+) 10 Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anthony Skubic Catherine Rook 21050 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank A. Fimowicz, Jr.-Son 1617 Kreitler Valley Rd. Forest Hill, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Toensee 22. Name and Address of Facility Evans Funeral 8800 Harford R Chapel Cremation Services Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Physician/ HEPATIC FAILURG ease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ADENOCIACINOMA METH STATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): PANCREATIC ADENOCARCINOMA physician and s the burial-trans that initiated events or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 1 ☐ Yes ∠ ⊭ g ☐ Unknown should be detached 9 Unknown signed by 1 Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe this certificate has page 2 1 Yes 2 No Yes 2 🔀 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? (P Hospital: 2 🔀 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number December 27, 2211 D0025010 Nold us 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 8831 Still HILL ROFILD BALTINGE, MD SERGNA R. NOLAN, M.D.

State Registrar 32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 25, 2011 9:25P M George Henry Frank Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland Months Davs Hours 218-42-2590 Director 67 1 🗶 M 2 🗆 F August 4,1944 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Timonium Maryland Baltimore 1 Yes 2 X No 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 21093 223 Chantrey Rd. United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Year or Dates, 1962–66 Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) construction construction worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edna Shugars Henry Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Frank/wife 223 Chantrey Rd. 21093 Timonium, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Dulaney Valley Mem GardDec. 25,2011 Timonium, Maryland Mitchell-Wiedefeld Funeral Home, Baltimore, 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between neumonia Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or injury that initiated events resulting in death) Last iding physician and ise as the burial-trar Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death the Unknown 9 Unknown P.O. ed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Hospital or Attending Physician; The law requires Completed . Were autopsy findings available prior to completion of cause of 24a. Was an ate has t page 2 s autopsy performed? Yes 2. N death? ena WI 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending thours after death.

uneral Director; Afely filled in by the fu 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) היוח 24 hours אפ **Funeral Dir.** אי filled in bv 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hou

To the Fune

completely fi 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month Day, Year)

State Registrar pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JUSHE

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10f per fh g922 12-27-11 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 2011 DECEMBER 06:53P M IRVING FENICHEL Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WINDSOR MILL 3416 JANVALE ROAD Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) **Director** 084-18-8069 1 🛛 M 2 □ F 09/22/1925 NY 86 Usual Residence of Deceden or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No MD BALTIMORE WINDSOR MILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 21244 3416 JANVALE ROAD 21144 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural", 3 Midowed 4 ☐ Divorced Specify: Completed WHITE Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 5+ ENGINEER DEFENSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ LOUIS FENICHEL AUGUSTA BLOOM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUIS FENICHEL / SON 6434 SEWELLS ORCHARD DRIVE, COLUMBIA, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION, INC 12/23/2011 HAMPSTEAD, MD any inj Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Ce 529 disease or condition resulting in death) Medical Examiner C1210105 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was a page 2 perform 1 ☐ Yes 2 ☐ No Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural 5 Pending injury Investigation M 2 🔲 Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 24 hours a Funeral I Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Day Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Melvin Lane Garritt 2011 December 3:37 Medical 4a. Facility Name (if not institution, give street and number)
Suburban Hospital Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Bethesda If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 069-18-7912 88 Hours 1/18/1923 13 M 2 - F Director NY Usual Residence of Decedent 28a-f shov 10b. County Montgomery 10a. State MD Oc. City, Town or Location Bethesda 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8001 Custer Road IISA 23a Funeral 20814 items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Procest No WWII 010 δ 1 Never Married 2 Married 1xxYes If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2xx No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Construction Be 18. Mother's Name (First, Middle, Maiden Surname)
Mabel Lane 17. Father's Name (First, Middle, Last) J. Stanley Garritt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5519 Palomino Way Frederick, CO 80504 Peter Thomas Garritt, son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 12/27/2011 Beltsville, MD 21. Signature of Tipe 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Vear's Death Coronary Heart Disease Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Atherosclerosis vears Sequentially list conditions, Examine Directo for an airconsequence on cause. Enter Underlying Cause (Disease or linjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 13/24/11 the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aortic Valve Stenosis 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 1 Yes 2 No **Division of Vital** Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 🔼 No Other: Certificate: To 1 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending MELVIN within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) 06019 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. AMENDITEM# IPETPHYS# 20a-c, 22perrh, 6922, 1272/720 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vincente Gallardo Day **Physician** ember 05, 2011 C11-2 20 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year
Months Days Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Min **Funeral** 1 ▼ M 2 □ F 59 Oct 24, 1952 Columbia Director 216-78-4371 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a State 28a-f show 1 ☐ Yes 2√ No Director MD Baltimore Dundalk Examiner must be notified 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö 23a 408 Westfield Road 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2 👿 No 21215-0036 o, Specify. Specify: hispanic <u>Ş</u> 3 ☐ Widowed 4 🕅 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 bakery <u>plant manager</u> unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Baltimore, Maryland Be and Mental ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S t of Health ; 21767 13811 Village Mill Road Maugansville, MD Armando Gallardo/son 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 Decremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important; If ite any injury or ott Dec. 15, ake Crem.

2011

Beltsville, MD

22 Name and Address of Facility Cafa/Stephen D. Lohrman P.A.

3717 Green Pastures 655 W Baltimore, MD 27286

Raltimore, MD 21201 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. Baltimore, MD 21286 Interval Retween r heart failure. List only one cause on each line. nset and Death Pulmonale Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Hypertension **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease avents) Examiner eficiency Virus Human Immunod that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) nding physician a use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Live birth 2 Fetal death Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) 2 🗌 No 2 No 1 🗌 Yes 1 🗌 Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) completely filled in by the funeral director, Be Hospital: 1 Inpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 🗆 DOA 5 ☐ Residence 6 ☐ Other (Specify) ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury Natural 5 Pending investigation 1 Yes 2 No death. ☐ Accident after death Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December OS, 2011 5-000 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHUENEMAN 4940 Eastern Avenue, Baltimore, MD, 21224 RON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ A^{M} Gilbert James Merrill 2011 11:00 December Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bel Air Harford 204D Chaucer Lane . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Min (Month, Day, Year) 392-16-9697 Usual Residence of Decedent 97 **Director** 1**X**XM 2 □ F Lake Geneva, WI February 6,1914 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Bel Air notified Harford Maryland 1 ☐ Yes 🏋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Medical Examiner must be 23a 21014 United States of America 204D Chaucer Lane "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc S O 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White Completed 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) S.C.M. Pignents than " College (1-4 or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Chemist Glidden Paint 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Annie Hague William Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 Old Field Court, Bel Air, Maryland 21015 Mary Gilbert-Taylor - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel and Cremation Services Bel Air 1 Burial 2XXCremation 3 Removal from State 12/22/11 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licen 2. Name and Address of Facility Evans Funeral Chapel and Cremation Services - BelAir 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ mon tes disease or condition resulting in death) CHE Medical Due to (or as a consequence of): **Examiner** MSCUD Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Directo for as a par section recon Cause (Disease or injury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical D m Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Unknown 9 Unknown g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Anemin Completed Were autopsy findings available prior to completion of cause of death? renal Insulficance 24a. Was an autopsy performed? Yes 2 X No page 1 Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Tes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner_of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1) 3/295 12/22/11 completed cause of death (Item 23a) (Type, Print) 21266 Bestmere K10852 32 Registra Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ruth Florence Grimm 1030 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Harford Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours Min **Director** 1 🗆 M 2 💢 F 173-12-9427 Usual Residence of Decede Maryland 91 Yrs 11-7-1920 28a-f shov 10d. Inside City Limits 10a. State 10b. County Ħ 10c. City, Town or Location Director notified 1 Yes 2 XNo Md. Harford Joppatowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If them 27 is anarked other than "natural", or items 23a or limportant: If them 27 is anarked other than "natural", or other traumatic event, the Medical Examiner must be 1 any lijury or other traumatic event, the Medical Examiner must be 1. Funeral 526 Anchor Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 X No ☐ Yes If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Specify 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Child Care Provider Daycare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helga Chelman James D. Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joppatowne, Md. 21085 Kevin Grimm Son 526 Anchor Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Churchville Pres. Cem | 12-24-2011 | Churchville, Md. 22. Name and Address of Facility 21. Signatura of Funeral Service License Schimunek FuneralHome Of BelAir 610 W. MacPhail Road Bel Air, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to lor as a c cause. Enter Underlying Cause (Disease or injury Examin and that initiated events resulting in death) Last Due to (or as a consequence of) physician ar Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the Unknown P.O. signed by Part II**. Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 1 Tyes Yes funeral director, 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes ER/Outpatient 3 DOA ပ 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) work?
1 Yes 2 No 5 Pending injury 1-Natural Accident Investigation completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nume Practition of To the basis of your death occurred at the time, date and close to the cause(s) are manner as stated. 29a. Certifier 29b. Signature and title of certifier D60768 MI 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUHAMMAD JOKHADAR, 500 Upper Chesapeake Dr, Be I Air, MD 21014 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Richard J. Greul, Sr. December 2011 9:40P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Gilchrist Hospice Balto. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 213-28-7435 1 ¥ M 2 □ F **Director** 82 Yrs April 7,1929 Maryland Usual Residence of Deceden 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Parkville Balto. Md. 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral items 23a 8810 Waltehr Blvd Apt. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify Completed 3 Widowed 4 Divorced 1953-1955 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Repairman Lucent Tech. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Otto J. Greul Agnes M. Trabert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 3206 Parkville, Md. 21234 8810 Waltehr Blvd. Catherine R. Greul Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 12-23-2011 Atlantic CremATORY Glen Burnie, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. Shoumon cosynve 9705 Belair Road, Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) a ending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: f r use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performe 2 🗌 No Yes 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 \square Pending within 24 hours after death. To the Funeral Director; A Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Cectifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 7821500C 12-22 - 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Philip Shaleen, 6701 N. Charles St. Suite 4105, Baltimere, MD 21204 Q 31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 20^{Day}2011 7:00P Physician/ MARY MARTHA **GEIPE** Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Maria Health Care 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 01/05/1923 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 M 2 XX Maryland **Director** 20-14-7541 88 Yrs Usual Residence of Dece 10d. Inside City Limits 28a-f shov 10c. City, Town or Location at 10a. State 10b. County Director items 23a or 28a-f s er must be notified 1 Yes 2 XXNo Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21212 6401 North Charles Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 XX No Black White etc. XX Never Married 2 Married ō ģ ould be filed within . . and Mental Hygiene. is marked other than "natural", or matic event, the Medical Exam Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: If Yes, Give Year or Dates. Specify. White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Parochial School Teacher Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) and Mental I ည Anna Croghan Joseph Geipe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6401 N Charles St. Baltimore, Maryland 21212 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. S. Bernice Feilinger SSND 20b. Place of Disposition (Name of cemetery, crematory or other place)
VIIIa Maria Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date XX Burial 2 Cremation 3 Removal from State Glen Arm, Maryland 12/28/2011 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner di son re erollascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit the Hospital or Attending Physician: The law equires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month Day Year Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 autopsy performe 1 Yes 2 No Yes 25, Was case referred to medical 26. Place of Death Check only one) Certificate: To Be 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b, Time of 28d. Describe how injury occurred funeral 27. Manne of Death iniury 5 Pending Natural Accident Investigation after death Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗌 only one 29b. Signature and title of certific 71.2011 MW ddress of person who completed cause of death (Item 23a) (Type, Print) 7 693

DHMH 17 Rev 06-2011

State Registrar 32. Registra s Signa

ork

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:10 A M 2011 December Jane Walter Gastilo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Hospice Casey House Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Numbe 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Days Hours 117-20-3459 **Director** 1 M 2 X F 85 Yrs June 1, 1926 New York Usual Residence of Decedent 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20902 United States 2303 Dennis Avenue death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify. White "natural", Completed 3 Widowed 4 X Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Government Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Gertrude Sommer Earl Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Carmen Gastilo Machuga / Daughter 4411 Gladwyne Drive, Bethesda, Maryland 20814 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State December 27 Silver Spring, Maryland Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2011 21. Signature of Furreral Service He Robert A. rumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Complications of Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying one to for as a sor sequence of use as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 🛣 No Month Year Day 5 Other (specify) Pregnant at time of death detached g Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 should be Records, Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 X No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛛 Other (Specify) Hospice this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred After injury 1 X Natural 5 Pending _ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24 hours after death. Funeral Director: Af within 24 hou

To the Fune

completely fi

> State Registrar

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Joseph,

7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29b. Signature and title of certifie

Bindu C.

31. Date filed (Month, Day

6001 Muncaster Mill Road, Rockville, Maryland 20855

29c. License number

D60634

29d. Date signed (Month, Day, Year)

December 23, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rosalie Mary Stambaugh Griffin 9.54 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛭 F Jan. 5, Yel 1938 Months 73 219-34-2318 Maryland Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🔀 No Maryland Carroll Union Bridge 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 5282 Middleburg Rd. 21791 U.S.A. and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 XMarried "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced White th and Mental Hygiene.
It is marked other than "natul traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) grocery store 12 farm wife/ stock worker dairy /retail grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John A. Buffington Mabel A. Fogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau once. Milton W. Griffin/ husband 5282 Middleburg Rd. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Pipe Creek Cemetery | 12/23/2011 4 ☐ Donation 5 ☐ Other (Specify) nr. Linwood, MD Signature of Mineral Service Lice 22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that found the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ E MBOLUS disease or condition resulting in death) DULMONARI Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buna Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death in the past 12 mor hs? Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**O 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural injury 5 Pending Division Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Dame Chihache dh 12-20-11 D0018200 podle Rd, WESTMINSTER, MD 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NACIANNAMD, 700 A Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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				-	-	-

		1- For State Certificate of Death		Reg	2 U 1	1 4130
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Shirley Garrett	ď	Date of Death Month December	Day Year 18 , 2011	3. Time of Death 0853 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location Union Memorial Hospital Baltimore			4c. County of Death N/A	
Funeral Director		106-34-9362 1 Months Days Ho		. Date of Birth 7 / 9 / 4	(MM/DD/YYYY) 9. Bir 4 Foreig Co	thplace (State or gn NY untry)
te Maryland or 28a-f show any fied at once.	ctor	Usual Residence of Decedent 10a. State		100	g. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
th the Ma 23a or 28 notified a	I Director	821 E. 34th St. 21218			USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes 2 No 15. Decedent's Education (Specify only highest grade completed) 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Control If Yes, specify Cuban, Mexical If Yes,	can, Puerto Rica	an, etc.)	14. Race - Amer White, etc. Africal SpecifyAmed	c.
1036 rithin 72 hou ene. er than "nat	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 11 College (1-4 or 5+) Telemarketer			Real Es	
215-0 be filed w ntal Hygic rked othe	Be Co		ther's Name (Fir ama Ja		aiden Surname)	
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	٩	19a. Informant's Name/Relationship (Type, Print) Wanga Garrett-Mateo/Daug. 19b. Mailing Address (Street and N 33 Cooke Ave,]	Brookl	yn,NY	11226	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other thinlary or other traumatic event, the Med		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview (Cem)Crem.	12/22	:/11	20c. Location - City or Balt., MD	Town, State
Balt permit. Departi Import injury		21. Signature Fundal Service LicentSee 22. Name and Address of Factorial Service LicentSee 5126 Belair	Mari Rd,Ba	Pt.,M	ose F.Sv D 21206-	S PA 5105
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	es cardiac or res	spiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underwing Cause		·		
uted id iansit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
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Box 68760, e death certificate be the attending physicied for use as the buri	Physician/M	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ector 4 Pregnant at time of death 5 Other (Specify) 9 Unknown 9 Unknown 1 Unknow	opic pregnancy		23d. Date of deliven Month	/ Day Year
res that the d signed by the be detached	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	ı Part I.		acco use contribute to 2 ✓ No 3 Prot	
Division of Vital Records, P.O. Box 68' To the Etopital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as I	Completed			24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
/ital Re- rsician: The us certificate director, page	æ	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4	, ,		esidence 6 🗸 Other	: Scene
n of \ding Phy	라. 1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Wo	/ork? 28d		w injury occurred	
Division of Vital Rec pital or Attending Physician: The ours after death. teral Director: After this certificate filled in by the funeral director, page	Certification:	Accident Specify Homicide Specify Rowhome Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, (Specify) Rowhome	, etc. 28f.	or Town, Sta		ral Route Number, City
To the Hospital within 24 hours To the Funcral completely fille	ल	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.				
	Ž	29b. Signature and title of certifier 29c. License numb O.C.M.E.	per		29d. Date signed (Mo. December 21, 20	
31		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Stre	eet, Baltimor	re, MD 212	223	
Sta Registr		31. Date filed (Month, Day, Year) DEC 2 7 2011 32. Registrar's Signiture				
DHMH 17 Pay 1/20	01	PLONIAL		OCM!		

Howard Patricia

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			For State	State of M	aryland /		icate of D				21111	41306
			Registrar 1. Decedent's Name (First, Middle, La	st)	-	Ochum	icate of B	Catri	2. Date of De	Reg. No ath	0. 2 0 1 1	3. Time of Death
н	Physicia Medio		Patricia Ann	Howard					Month	Da / C	Year 2011	6:12 PM
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			Franklin SGC 5. Social Security Number 6.5	iare 1-05	e (In yrs. last b		ROSC (Under 1 Year	If Under 24 Hrs.	3. Date of Bir		Baltin	hplace (State or Foreign
	Funeral Director		233-52-3367	_ M 2 K F / . ^ 9	77		onths Days	Hours Min.	(Month, Da	1 ^{Year)}		est Virginia
91.00	d ow t	L	Usual Residence of Decedent 10a. State 10b, County		10c. City, To	un or Looptic	n					10d. Inside City Limits
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	or 28 e noti		10e. Street and Number			1	10f. Zip Code			10g. C	itizen of What Co	
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	ritem ritem inern		11. Marital Status	12. Was Decedent I Armed Forces? 1 \(\sum \) Yes 2	Ever in U.S.	13. Was	Decedent of His s, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White	
036	safter ral", o Exam	ed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates.	, No	1 🗆	Yes 2 No	Specify:			Specify:	White
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/lan	d be fi Mental arked rtic ev	2	Virgil Flint					Lula	Losh			
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Baltimore,			1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		ceme	tery, cremato	ory or other place	•	Dec 22 2011			le, Maryland
altii	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen		MOISS	Ť		enr Facricol Fu	neral Al	tern	atives	
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			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of			o not enter th	e mode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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Вох	e deat the at thed fo	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of death	n 5∐01	ther (specify)				WOTH	Day Teal
P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions	-	out not resulting	g in the unde	erlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
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of V	Attending Physic ar death. ector: After this ce by the funeral dire	e: To	27. Manner of Death	28a. Date of inju		. Time of	28c. Injury	at	28d. Describe		6 Other (Specially occurred	:ity)
on	ending sath. or: Aft he fun	ficat	1 Natural 5 Pending 2 Accident Investigation		y, rear)	injury	M 1 □	? Yes 2 □ No				
Division of Vital Records,	al or Attend after death Director: / d in by the f	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ury - At home, c. <i>(Specify)</i>	farm, street,	factory, office		28f. Location (City or Tox	Street a vn, Stat	nd Number or Ru e)	ral Route Number,
۵	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Phy	/sician: To the best of	my knowledge	e, death occu	ured at the time,	date and place, a	and due to the ca	ause(s) a	and manner as sta	ated.
	he Ho. in 24 h he Fur pleted	Medical	(Check 2 Medical Exan	iner: On the basis of e se Practioner: To the	examination and	d/or investigat	tion, in my opinio	n, death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner stated.
	Vith Con	5	29b. Signature and itle of certifier	14			29c. License	number	20	29d. D	ate signed (Monti	h, Day, Year)
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	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1	7.0111	V. 1V C. E	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100	111111111111111111111111111111111111111	
	Registr	ar	LIEU O I ZUII 🔑	A.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ December 2011 9:00 Margaret Virginia Harmon Medical 4a. Facility Name (if not institution, give street and number) 4c, County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Riverview Care Center Essex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 578-24-6933 **Director** 1 □ M 2 🔀 F 03/14/1924 Washington, D.C. 87 Usual Residence of Deced əms 23a or 28a-f show r must be notified at 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location Director 1 Yes 2XXNo Maryland | Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 18 Box Circle 21221 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: "natural" Completed 3 Widowed 4XXDivorced White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home 10 of Health and Mental Hygie If item 27 is marked other Ir other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nettie Colburn Edwin Staub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Bonnie Snyder (Daughter) 18 Box Circle, Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State cemetery, crematory or other place) P Department or Important: If any injury or Cedar Hill Cemetery 12/29/2011 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Fallinski Funeral Home,}
1407 Old Eastern Avenue, Essex, neral Simo P.A. Maryland 21221 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Onset and Death nediate Cause (Final Physician/ d ease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami and as the burial-trar that initiated events resulting in death) Last the attending physiciar Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SCHIZO PHRENIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an tor: After this certificate has the funeral director, page 2 autopsy death? 1 🗌 Yes 2 1 No 2 1 No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death eck only one) examiner? Hospital 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) of Death 28b. Time of 28c. Injury at s after death. Certificate: 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) 5 Pending injury 1 V Natural Accident Investigation 2 Accident
3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined within 24 hours a

To the Funeral C

completely filled Hospital Medical 29a. Certifier 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Dertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print în Black Indelible Ink. Ensure All Copies Are Legible.

		-	- State Registrar	30f Maryland	d / Depa Cer	rtmər tificat	27720 e of D	99 th 3 0 eath	nd Men	ntal Hyg R	iene _{eg. No.} 2	011	4130	8
			Decedent's Name (First, Middle, Last)						2. [Date of Deat	h	V	3. Time of Death	٦
	Physicia Medic		Ella Rose Hubbard						D	ecemb	er ^{Day} . 2	20 ^{Yea} l	10:15 PM	╛
and the same	Examin		4a. Facility Name (if not institution, give street and	number)				Location of D			4c. County of Death			
The same of			Holy Cross Hospital 5. Social Security Number 6. Sex		11:41-4-)		ver S	Spring If Under 24		Date of Birth		gomery	lace (State or Foreign	4
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐	7. Age (In yrs. Ia: 58		Months								
			Usual Residence of Decedent											\dashv
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	vith th	ral	11314 Sperry Stream	Way		101. 2		20720			USA	What ooal	uy.	
	eath v	un-	11. Marital Status 12. Was	Decedent Ever in U.S.	. 13. V	Vas Dece	dent of His	panic Origin'	? (Specify	Yes or No-	14. Ra	ce - Americ		┨
9	fter d	þ	1 XNever Married 2 Married 1 If You	ed Forces? Yes 2 🛛 No s, Give				, Mexican, P	uerto Ricar	n, etc.)	Bla Specifi	ck, White,	etc. Lack	
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Baltimore, Maryland 21215-0036	ਦੇ ਲ ਤੋਂ ਤੋਂ ਲ ਤੋਂ ਤੋਂ		19a. Informant's Name/Relationship (Type, Print) Cecilie V. Johnson/ex	xecutor	19b. Mailin	g Addres Cand	s (Street al	nd Number o Vav Lo	or Rural Roll a Alt	ute Number,	City or Town, A 94024	State, Zip (I	Code)	١
ē,	and 2 s Health tem 27		20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Na	me of		Date		20c. Location		wn, State	\dashv
mo I	Page 1		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 💢 Donation 5 ☐ Other (Specify)		metery, crem	natory or	other place)				,		
ati	permit. Page Department Important: I any injury or once,		21. Signature of Funeral Serve e Licensee Ronal Serve e Sicensee	Mirector	22	Name a	nd Addres	Sof Facility	oard	655 W	. Balti	more	Street	٦
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		~	23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause of	that caused the death on each line.	. Do not ente	r the mod	de of dying	, such as car	rdiac or res	spiratory arre	est,		Approximate Interval Between	
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la.		ner	Sequentially list conditions, if any, leading to immediate Du	ie to (or as a consequ		10-	tels Voerd							٦
	uted d ansit	Examiner	Cause (Disease or injury that initiated events M	letastatic	tastatic Endometrial Cancer									
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9	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	d	TE MCES CO	- Hung	<u> </u>	a i ci	TCOHCC						\exists
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000	has b	mple							_	24a. Was a autops	sy		psy findings available mpletion of cause of	
m m	n: The la ficate ha or, page		25. Was case referred to medical				00 51	(Dardle	(0)	perfor 1 Yes	2 X No	1 Yes	2 No	
/ita	ysician: is certific director,	o Be	examiner?	1 ☐ Inpatient 2🏋	EB/Outpotion		Othe	r:			ence 6 🗆 Ot	hor (Specifi	·1	
of/	g Phy er this neral o	e: To	27. Manner of Death 28a.		28b. Time of		28c. Injury	at			ow injury occur		/	_
E .	endin eath. or: Aft he fur	ficat	2 Accident Investigation	(IVIORIII, Day, Teal)	injury	М	work?	Yes 2 No	ю					
Division of Vital Records,	or Att	Certificate:		Place of Injury - At hor building, etc. (Specify)		et, facto	y, office			Location (St City or Town		ber or Rura	Route Number,	
Ō	• Hospital or Attending Physician: The law requires that the death 24 hours af er death. • Funeral Director. After this certificate has been signed by the attertely filled in by the funeral director, page 2 should be detached for		29a. Certifier 1 X Certifying Physician: To	the best of my knowle	adde death o	occurred	at the time	date and no	ace and di	ue to the car	use(s) and mar	ner as stat	ed.	_
	To the Hosp within 24 ho To the Fune completely f	Medical	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Practiti	ne basis of examination	and/or invest	tigation, ir	my opinio	n, death occu	urred at the	time, date an	nd place, and d	ue to the ca	use(s) and manner state	d.
	To the withing To the Comp	2	29b. Signature and title of certifier		, s oage,		c. License		- p t		29d. Date sign			
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			31. Date filed (Month, Day, Year)				Japit	<u> </u>						_
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			State of Maryland 1tem 27 State of Maryland	1,1272	772011 of H	lealth and N			1 1 1 2 0 0
			Registrar 1. Decedent's Name (First, Middle, Last)	Cel	uncate or D	calli	2. Date of Dea	Reg. No. 2	3. Time of Death
	Physicia Medic		Henry Randolph Hughes	, Sr.			Decembe	r 13, 2011	
and the first	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			4c. County of Dea	
-			Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. la.	et hirthday)	Silver	Spring If Under 24 Hrs.	8. Date of Birt	Montgom	ery irthplace (State or Foreign
	Funeral Director		229-20-9580 1 M M 2 □ F 84	Yrs.	Months Days	Hours Min.	(Month, Day	(, Year) C	ountry)
100	d wo t	L	Usual Residence of Decedent	, Town or Lo	nation		Apr. 14	, 1927 Vir	ginia 10d. Inside City Limits
	arylan a-f sh fied a	Director	Maryland Prince George's Bow		cation				1 ☐ Yes 2 X No
	the Ma or 28 e noti		10e. Street and Number	16	10f. Zip Code			10g. Citizen of What C	Country?
	s 23a	Funeral	11603 Legend Glen Drive		20720			U.S.A.	
	r item	/Fur	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?		Vas Decedent of His f Yes, specify Cubar			14. Race - Am Black, Wh	
920	s after ral", o Exam	ed by	1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No If Yes, Give 1 ☐ Yes Care Year or Dates.	1	□ Yes 2 🛚 No	Specify:		Africar	n American
2-0	2 hour	plete	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupa kind of work done di		ina	16b, Kind of Busines	
21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Post	O NOT use retired)	g	9	U.S. Post	Office
	e filed within 7 rtal Hygiene. ed other than event, the M	Be	17. Father's Name (First, Middle, Last)	103	- India	18. Mother's Nam	e (First, Middle,		
ylar	ld be f Menta arked atic ev	입	Randolph Harrison Hughes			Hortens	e Macon		
Maryland	e 1 and 2 should be filed within 72 hours after death with the Manyland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Henry Hughes (Son)	1				, City or Town, State, 2 MD 20720	Zip Code)
e,	and 2 s Health tem 27		20a. Method of Disposition 20b. Pl	ace of Dispo	sition (Name of	:	Date	20c. Location - City of	or Town, State
mo	Page 1 nent of int: If it				natory or other place Nat'l Cem	9)		Triangle	
Baltimore,	permit. Page Department of Important: If i any injury or once.		21. Si nature of Juneral Service License	J ₂ 22	Name and Address	s of Facility kins, Jr	. Funera	al Home, Irond, VA 232	1C.
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.		•				Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition ASCVD						Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequently pertently) Due to (or as a consequently)						
	MT AT	ner	Sequentially list conditions, b. Due to (or at a contraduct)						
	cuted nd transit	xami	cause. Enter Underlying Cause (Disease or injury that initiated events C. Diabetes						
_	death certificate be executed re attending physician and ed for use as the burial-transit	dical Examine	resulting in death) Last Due to (or as a conseque	ance of):					
1200	ficate t g phys	ledic	d						
x 687	eath certifice attending p I for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 1 ☐ Live Birth 2 ☐ Fetal		Ectopic pregnancy	/		23d. Date of c	lelivery
Вох	that the death or ned by the atter a detached for i	Physician/Me	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of de 9 Unknown 9 Unknown		Other (specify)			Month	Day Year
P.O.	The law requires that the arte has been signed by the page 2 should be detach	by Ph	Part II. Other significant conditions contributing to death but not resu	ılting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds,	requires the been signer should be	ted k					1 🗆 `	Yes 2 No 3 No	Probably 4 X Unknown
COL	law re has be e 2 sh	Completed					24a. Was autop	sy prior to	autopsy findings available completion of cause of
Re	sician: The law r s certificate has b lirector, page 2 s		25. Was case referred to medical				1 Yes	rmed? death? 2X No 1 □ Y	es 2 🗆 No
Vita	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 🗓 No Hospital: 1 ☐ Inpatient 2 🖺 E	ER/Outpatier	Otho	r:		lence 6 Other (Spe	aciful
of	tending Phy leath. :or: After thi the funeral			28b. Time of injury				ow injury occurred	
ion	Attending or death. sctor: After by the fune	Certificate:	2 Accident Investigation		M 1 🗆 `	Yes 2 No			
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>	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of my	and/or invest	tigation, in my opinior	n, death occurred a	t the time, date a	nd place, and due to the	e cause(s) and manner stated.
ン	To the I within 2 To the I comple		29b. Signature and title of certifier		29c. License	number		29d. Date signed (Mor	nth, Day, Year)
0			M.D.			4296		DECEMBER,	13, 2011
-			30. Name and address of person who completed cause of death (Item: R. Nguyen, M. D. 1500 Forest			lver Spr	ing, MD	20910	
	Stat		31. Date filed (Month, Day, Year) 32. Distrar's Signatu	ire	. 4.1				
	Registra	al.	DEC 2 7 2011 / Deve	C. A	aver				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:30 P_M Edwin H. Howes December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Days Months Hours (Month, Day, Year) 215-05-6692 **Director** 1 XM 2 □ F 93 Baltimore, MD June 21,1918 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director Baltimore Parkville MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9130 Avondale Road 21234 United States Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian an "natural", or iter Medical Examiner Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Manufacturing Foreman other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Howes Elsie Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin Howes- Son Sidehill Drive Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If its any injury or of December 1 XBurial 2 Cremation 3 Removal from State Gardens of Faith Cametery Rosedale, MD 4 Donation 5 Other (Specify) 27, 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
8800 Harford Rd. Parkville, MD 21234 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im Jediate Cause (Final Pulmony Disease Physician/ di-ease or condition esulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on use as the burial-trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated gnature and title of co 29d. Date signed (Month, Day, Year) D0071187 12-22-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swife 4105, Balthrowere, MD 21204 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) December 25, 2011 Physician/ 9:00 A M James Robert Higgins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hunt Valley Baltimore 1510 Applecroft Ln. 8. Date of Birth
June 9, 1928 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days XXM 2□F Months Hours Min. Vermont 83 Director 009-20-3995 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a State 10c. City, Town or Location 72 hours after death with the Maryland Director 1 Yes XX No Baltimore Reisterstown MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21136 U.S.A. 1023 Green Hill Farm Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14 Race - American Indian. Examiner Armed Forces? Black, White, etc. o 1 Never Married XX Married ρ Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates, WW II Specify: White Completed 3 Widowed 4 Divorced marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Baltimore County life. DO NOT use retired) Athletic Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher/Director Schools it. Page 1 and 2 should be filed wi rtment of Health and Mental Hygin rtant: If item 27 is marked other njury or other traumatic event, ti Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk . Edith McFadden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Helen Barbara Higgins /Wife 1023 Green Hill Farm Rd. Reisterstown MD21136 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Faiths
Crematory & Chape 1 12/27/11 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. 1 Burial 2XX remation 3 Removal from State 4 Donation 5 Other (Specify) Manchester, MD 22. Name and Address of FacilitEckhardt Funeral Chapel P.A. 21. Signature of Mer Service Lense 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final MELANUMA MALIGNANT Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown g Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION, CARDIAG PACEMAKET 1 Yes 2 No 3 Probably 4 Unknown OSTEOARTHRITIS 24b. Were autopsy findings available prior to completion of cause of death? ASTIHMA, 24a. Was an aw has page 2 autopsy performed' or Attending Physician: The 2 🗆 No 1 🔲 Yes 2 N _ Yes 25. Was case referred to medica B 26. Place of Death (Check only one) director, examiner? Hospital Other: 2 🔊 No 1 🗌 Yes HUNGE مِ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ther (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Natural s after death.

I Director: Aft d in by the fur Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) within 24 hours at To the Funeral D completed filled in Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) 126394 len 12/27/11 Donali 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6535 NICHARLES ST, 450 TOWSON, MDZIZOG WEGNEIN DONALD T 31. Date filed (Month, Day, Year) -State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Sue Boatman Hare 23, 20°11 Physician/ December 00:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death . County of Death Worcester Examiner Berlin Atlantic General Hospital 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country) MS 1 □ M 2 🗓 F Months Hours Min 1672471924 87 Yrs Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland items 23a or 28a-f shoner must be notified at 10b County Worcester 10c. City, Town or Location Berlin **Funeral Director** 1 Yes 2X No 10f. Zip Code 21811 10e. Street and Numbe 10g. Citizen of What Country? Offshore Lane 64 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. If Yes, Give Year or Dates SpecifiWhite "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Real Estate Broke (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) Cellege (1-4 or 5+) Estate Broker Real Estate Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any pirary or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Sallie Cole ပ William Boatman 19a. Informant's Name/Relationship (Type, Print) Jeff V. Hare / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 64 Offshore Lane, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XI Cremation 3 Removal from State Beltsville, MD Chesapeake Crematory 12/27/2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens Orota Mar shall ^{22. Name and Address of Facility}
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death ceruincare be accommoditionally hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 2 No 1 ☐ Yes 2 년 9 ☐ Unknown 9 Hipknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 1 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying-Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certif 29d Date signed (Month, Day, Year) S. NISAR, M.D DO068576 1 5W person who completed cause of death (Item 23a) (Type, Print)
EEHA NISAR 9 7 3 3 30. Name and address of SABEEHA DR, BERLIN TEALTH WAY 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Deborah Colleen Hi11 201 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square ti more Kose Hos 8. Date of Birth
(Month, Day, Year)
May 10, 1948 9. Birthplace (State or Foreign Country)
Maryland Age (In vrs. last birthday 24 Hrs. Funeral If Under 1 1 □ M 2XXF Months Hours Min. 63 Yrs. Director 213-52-0315 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland Harford Bel Air ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be Funeral with 2010 White House Rd. 21015 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 5 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 XWidowed 4 Divorced Specify: White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) X-Ray Technician Medical and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပ Page 1 and 2 should be Charles Clark Albert Lowe Ordelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 of Health Department of Health Important: If item 27 any injury or other t Matthew Hill/Son 2010 White House Rd. Bel Air MDtimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12/24/2011 Glen Burnie 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Rd., Bel Air MD 21014 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or shock, or heart failure. List of predipplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Immediate Cause (Pinal Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transi ana Due to (or as consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No ☐Yes 2 🗷 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No iniury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 106952 12-22-2011 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD 2123 31. Date filed (Month; Day, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 78,2019 9:40 A John Wilbur Harrison Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Arbutus 5556 Link Avenue If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 215-10-1440 Days Hours (Month, Day, Year) **Director** 92 Nov. 10 1919 Maryland 28a-f show 10a, State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Arbutus MD Baltimore 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21227 5556 Link Avenue Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Completed 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Eberts & Harrison Inc. nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Bonding & Insurance Co. 4+ Chairman other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hallie Rosalie Kirby John W. Harrison Sr. of Health and N item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5518 Link Avenue Arbutus Maryland 21227 Joanne Baker-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ö 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Loudon Park Cemetery Dec.22,2011 Baltimore Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. f Muneral Service Licenses 1328 Sulphur Spring Road Arbutus Maryland 21227 alin Kal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) homic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P,O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performe death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 - No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier December 19, 7011 197 dress of person who completed cause of death (Item 23a) (Type, Print) Roli 31. Date filed (Month, Day, Year, State 7 DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 25^{Day} 2011 9:59 A Margaret Hartlove Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Months 215-05-2035 **Director** 1 🗆 M 2 🗶 F 5/5/1915 Maryland 96 or 28a-f show notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Mary land 1 Yes 2X No Perry Hall Baltimore 10e. Street and Numbe 5 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a Funeral U.S.A. 21128 20 Dovefield Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ¥ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Katherine S. Tine James W. Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 shat of Health a If item 27 is Carol A. McKinney / 20 Dovefield Road Perry Hall, Maryland 21128 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Mem. Park 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 12/30/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) of Foneral Service 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ esophacitis CROSIVE Medical resulting in death) to (or as a consequence of): **Examiner** hemio near Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Day to for as a ronsequence of Exam Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Por in the past 12 months?
1 Yes 2 Ho Pregnant at time of death the q 🗌 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementos 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 POther (Specify) Nussel 4 within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year)

December 25 2011 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST TOWSON MM

Registrar DHMH 17 Rev 06-2011

State

HANVES

AMON 31. Date filed (Month, Day) Year) MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#5perFH, G924, 2/6/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carol J. Hyde 2011 6:45 December AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours **Director** 1 M 2 XF 73 Yrs Oct. 30, 1938 Ohio Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits rector notified Baltimore MD. 1 Yes 2 X No Towson ō 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene. Fitem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be reason. Funeral 8202 Burnley Road 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 6:45 а.ш. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stull Dorothy Quittschreiber, Jr. John permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD. 21204 James R. Hyde/ Husband 8202 Burnley Rd. DECEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12-23-11 Parkton, MD. Bee Tree Cem. 4 Donation 5 Other (Specify) ^{22. Name Ruck Towson} Funeral Home, 1050 York Rd. Towson, MD. Signature of neral strvice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ENDOMETRIAL CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery CAROL HYDE PO in the past 12 months? Month Day Year 1 ☐ Yes 2 🛣 No 9 ☐ Unknown signed by the a ld be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy this certificate Yes 2 X No director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE ဂ္ 1 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; A Accident Suicide Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29d. Date signed (Month, Day, Year) 201 f person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month Day, Year) - > • > State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8, 18perFH, G922, 12727/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Q45PM 0 . Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner COMMUNIT CENIE 1 Year If Under 24 Hrs. 8. Date of Birt 4/28/1928 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Sex 14 M 2 □ F **Funeral** 228-24-6258 Hours Min. 83 Months VA Director Usual Residence of Decedent or 28a-f shov 10b. County 10a State 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at Director Baltimore MD N/AX ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244-3606 USA items 23a 3421 Washington Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever in U.S.

Armed Forces?

#∭ Yes 2 ☐ No

If Yes, Give Year or Dates. 1944–6 Black, White, etc. 9 ò 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced Amer. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event and once." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MD Drydock Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Be 17. Father's Name (First, Middle, Last)
Willie Hairston 18. Mother's Name (First, Middle, Maiden Surname) Bemnie Hairston Bennie ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21244 — 3421 Washington Ave, Windsor Mill, MD 3606 Sylvia Hairston/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Va 1/4/2012 20a Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Owings Mills,MD 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Hari P. 21. Signature of Funer Service Lie Close F.Svs, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): signed by the attending physician and de detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Year Month Day 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) å Hospital 1 ☐ Yes 2 🗶 No Other 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No iniury X Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) Vâ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 23, 2011 Sarvar Izedian 12:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Davs Hours Director 214-65-0266 85 1 🗆 M 2 🕱 F April 27, 1926 Iran Usual Residence of Deceden show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Maryland | Montgomery Rockville 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 6121 Montrose Road 20852 Ir an items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, or than "natural", or ite Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Khodadad Izedian Shirin Behman traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or any Parivash Mehrdadi/Daughter 12914 Ardennes Avenue, Rockville, Maryland 20851 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Parklawn Memorial 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State December 26 4 Donation 5 Other (Specify) 2011 Rockville, Maryland A. Pumphrey Funeral Home/ inc. 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert Bethesda-Chevy Chase, Inc. M01498 Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician disease or condition Chronic Obstructive Pulmonary Disease Medical resulting in death) Due to (or as a consequence of) Examiner Severe Mitral Regurgitation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Pneumonia and trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical Atrial Fibrillation 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Dementia Completed 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? Renal Failure 24a. Was an Jas autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No of Vital To the Hospital or Attending Physician: æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tyes 2 X No မှ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death s after death.

I Director; After the din by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Division 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide within 24 hours after

To the Funeral Direct

completely filled in by City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 L 3 L Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 00068160 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kimberly D. MD8600 Old Georgetown Road, Bethesda, Maryland 20814 Zuzak, State

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physiciar Medical Examin	1/	Decedent's Name (First Barry		an							Date of Death Month December	1	Year	3. Time of Death
· ·		4a. Facility Name (if not in University Hospit		e street and numb	per)			, Town, or imore	Location of		<u>Jecember</u>		County of Death	
Funeral Director		5. Social Security Number	1 <u>X</u>	9x 7.	Age (In yrs.	last birthda	Yrs. If Un-	ths Days		Min	B. Date of Birth	,	Foreig	thplace (State or gn untry) PA
ow any	Ī	Usual Residence of Deceding 10a. State 10b. C	ounty			y, Town or L								10d. Inside City Limits 1 Yes 2 No
th the Maryland 23s or 28s-f sho notified at once.	Director	10e. Street and Number			Da.	I C I III O	10f. Zi	ip Code			10	_	en of What Cou	71
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at one	- L	11. Marital Status 1 Never Married 2		12. Was Deced		J.S. 13		dent of His			fy Yes or No- can, etc.)			ican Indian, Black,
ours after d	2	3 Widowed 4 [15. Decedent's Education		If Yes, Give Year		16a. Dec	1 Yes	al Occupati	ion (Give I				Specify: Whi	
77	Completed	Elementary/Secondary		College (1-4	or 5+)		ing most of wo						nstruct	ion
21215-0036 Auld be filed within 7 Mental Hygiene. marked other than c event, the Medica	20	17. Father's Name (First, N Edward Jose 19a. Informant's Name/Re	eph Iv	an		10b M	lailing Addros		Agn	es He	irst, Middle, M 1en Ba	ran	urname) or Town, State	Zin Code)
MD and 2 sho alth and 27 is raumati	Ĺ	Keith A. Tra	ader-S		20b.	P.0	•	6 Har	man	West	Virgin	ia 2	·	, ,
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		1 Burial 2 Cre 4 Donation 5 Ot 21. Signature of Functions	her Specify:			lanti	or other place <u>Crem.</u> 22. Name and	atory	of Facility	Dec.2	4,2011	Gle	en Burni al Home	ie Maryland
Physician	1	23e: Part I. Enter the disea			ed the death		1328 S	u1phu	ır Sp	ring	Road A	rbut	us Mary	1and 21227 Approximate Interval
Medical Examiner		failure. List only one Immediate Cause (Final di or condition resulting in de	isease a.	Head Inj										Between Onset and Death
		Sequentially list conditions if any, leading to immediat cause. Enter Underlying (e Cause	Due to (or as a co	nsequence	of):								
ecuted and transit		(Disease or injury that initi events resulting in death)	Last d.	Due to (or as a co										
60, ate be ex hysician e burial		X UNPENDED IF FEMALE: 3b. Was decedent pregna	nt in the	AMENDED 23	come of preg				_				Date of delivery	
D.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit by Dhysician Macdinal Ex	i yalcıdı	past 12 months? 1 Yes 2 No 9			at time of d	eath 5	Fetal death Other (Spe		Ectopic	pregnancy		"	Month C	Day Year
ires that the signed by the be detached	3	Part II. Other significant o	onditions:	contributing to de	eath but not	resulting in	the underlyin	ng cause g	iven in Pa	rt I.			se contribute to	the cause of death?
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.											24a, Was ai autops perform 1 Yes 2	y ned?		topsy findings available completion of cause of es 2 No
Vital Rec ysician: The his certificate director, page	2 3	25. Was case referred to mexaminer? 1 ✓ Yes 2 N	įΉ	lospital: 1 🗸 Inpa	atient 2	ER/Outpa	atient 3 🗍 I		Other -	(Check only Nursing H	one)	Residenc	ce 6 Other	
sion of trending Ph death. ctor: After t y the funeral	- 12	27. Manner of Death 1 Natural 5 2 X Accident	Pending Investigation	VII.	y,Year) -16–11	fd 11	e of Injury 1:50 am	1	y at Work	No St	tairs	fe1	1 down	flight of
Division o To the Hospital or Attending Whith 24 hours after death. To the Funeral Director: After completely filled in by the fune		3 Suicide 6 4 Homicide	Could not a	(Specify)	I	arkin	street, factor			В	or Town, Sta altimo	re,M	09 Wash D.	ral Route Number, City nington Blvd
To the Ho within 24 To the Fu completel	בחוכם	(Check only	al Examiner	an: To the best of On the basis of e and manner state	xamination a	-	stigation, in m		death occ		e time, date a	nd place		e cause(s)
		0-0-			£ d			O.C.N					mber 22, 20	
X		30. Name and address of p Donna M. Vincen	ti, MD	Assistant Med	dical Exa	miner 9	900 W. Ba	altimore	Street,	Baltimor	e, MD 212	23		
Stat Registra	-	31. Date filed (Month, Day,	Year)	32. Regis	trar's Signat	ure barks	,							

Stephen Jimenek 11-09453 Please Typ UNK UNK St

1-09453 INK UNK		Please Type or Print in Black Indelible I			ble.	*				
INK UNK		State of Maryland / Department of Certificate of Ce			201	1 4132				
Physici Medical Exam	an/ iner	1. Decedent's Name (First, Middle,Last) Stephen Jimenez		2. Date of Death Month D December 1	av Year	3. Time of Death 0840 hrs				
)		4a. Facility Name (if not institution, give street and number) Rock Creek Park	4b. City, Town, or Location of Dea		4c. County of Death Frederick					
Funeral Director		5. Social Security Number 076-60-0951 6. Sex 7. Age (In yrs. last birthday)		1rs. 8. Date of Birth(1 1in. 11/06/	MM/DD/YYYY) 9. Birt Foreig 1964 Cou					
eath with the Maryland litems 23a or 28a-f show any ast be notified at once.	Director	Usual Residence of Decedent 10a. State	Holdenville 10f. Zip Code 74848		Citizen of What Coun	10d. Inside City Limits 1 X Yes 2 No				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens I benefit Without the Maryland Important. If liems 72 is marked other than "natural", or items 23a, or 23a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. W. 15.	74040 as Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Puer Yes 2 No specify: nt's Usual Occupation (Give kind of	rto Rican, etc.)	USA 14. Race - Americ White, etc. Specify: Whi	te				
1036 vithin 72 hou ene. er than "nat Medical Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 5+	nost of working life. DO NOT use r Emergency Manage	etired)	Private	- '				
21215-0036 ould be filed within 7 Mental Hygiene, marked other than	Be C	17. Father's Name (First, Middle, Last) James Jimenez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Jo	ne (First, Middle, Maio	S	7.0.1.				
and 2 shoul fealth and N tem 27 is n traumatic	오	Amanda Jimenez (Wife) 3560 20a. Method of Disposition 20b. Place of Disposi	g Address (Street and Number of 369th Road, Holsition (Name of cemetery,	denville,						
Baltimore, permit. Pages 1 as Department of He Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	remation 12		Hanover,					
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	Name and Address of Facility La 2818 E. Baltimor the mode of dying, such as cardiac	e Street,	Baltimore					
Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Contact gunshot wound Due to (or as a consequence of):	l of head			Between Onset and Death				
Scured and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.								
al an	Medical	■ MENDED23a,27,28a-f,pe	er me,g922 12-28	-11 sm	23d. Date of delivery					
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 Hours after death. the Function: After this certificate has been signed by the attending physici piletely filled in by the funeral director, page 2 should be detached for use as the burn	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fe	etal death 3 Ectopic pregither (Specify)	nancy		ay Year				
s, P.O. iires that the signed by the detache	ā	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		cco use contribute to the 2 No 3 Proba					
Division of Vital Records, rail or attending Physician: The law requiring a flow of the law requiring the law requiring the law requiring the law records. After this certificate has been sided in by the funeral director, page 2 should be	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of				
of Vital Physician er this certi eral directo	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 1 No Proposition Proposit			sidence 6 Other:	Scene				
Vision of variation of the death. Nicctor: After the funeral	Certification:	1 Natural 5 Pending (Month, Day, Year) fd 12-16-11 fd 8:30 28e. Place of Injury - At home, farm, street	0 am 1 Yes 2 X No	subject s	shot self	al Route Number, City				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		4 Homicide determined (Specify) found in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place, ar	Frederick and due to the cause(s)) and manner as state	d.				
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigal and manner stated. 29b. Signature and title of certifier	29c. License number		I place, and due to the Od. Date signed (Mont					
6		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		ecember 17, 20	11				
	nto	Jack Titus MD. Deputy Chief Medical Examiner 900 W. E 31. Date fleet (Month, Day Year) 32. Registrar's Synature		e, MD 21223						
Regist	rar	31. Date filed (Month, Day Year) 32. Registrar's Synature	/							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Miles Johnson 2011 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 12930 Woodburn Drive Washington Hagerstown Social Security Number ear If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** (Month, Day, Year) Hours 214-42-3583 **Director** 1 🗶 M 2 🗆 F Usual Residence of Decede 67 July 21, 1944 Maryland show notified at 10a State 10b. County 10c. City. Town or Location Director 28a-f Maryland Washington Hagerstown ö 10e. Street and Number 10g. Citizen of What Country? must be Funeral items 23a 12930 Woodburn Drive 21742 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 X Married 2 X No Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 'natural", Completed 3 Widowed 4 Divorced Specify: Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 International Salesman Tires other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental H မ Robert Allen Johnson traumatic Nellie Faunce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other traunonce. Melinda Gail Johnson / Wife 12930 Woodburn Dr. Hagerstown, MD 21742 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 12/26/2011 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M 23a. Part 1. Enter the deepen or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final Physician/ Cirrhosis of Liver disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to for as a porsequence off cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the at Id be detached for 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv performed? Yes 2 X No death? 1 TYes Yes 25. Was case referred to medical 26. Place of Death (Check only one)

3. Time of Death

3:43 A

10d Inside City Limits

1 Yes 2 X No

MD 21029

Approximate Interval Between

2 🗌 No

Onset and Death

Division of Vital To the Hospital or Attending

Be Hospital 2 XNo Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 5 \square Pending 1 🛛 Natural injury within 24 hours after uccur.

To the Funeral Director: A 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practif oner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D23623 December 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederic H. Kass 11110 Medical Campus Rd. Hagerstown, MD 21742 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 27 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 26, 2011 3:15 PM M Louise Kawich Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Franklin Square Hospital Rosedale If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 💢 F Days 1272671919 Pennsylvania **Director** 213-30-7367 92 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 "A" Wampler Road 21220 S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify 3 XWidowed 4 ☐ Divorced Specify: Completed White or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) filed within Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ည should be Remsburg Verda May and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Page 1 and 2 10236 Clearridge Road Everett, Pennsylvania 15537 Leroy Kawich (Son) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/2011 Bayview Crematory Baltimore, Maryland 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Bleed Intrachania disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transil Due to (or as a consequence of) Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 No ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 5 Pending work? Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number of City or Town, State) (2) A Warm Plan Rd M; Helfturg, MD 2122 4 Homicide determined home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a (Type, Print) 16 H:11 C 31. Date filed (Month, Day, Year) State

Registrar

Box 68760

Division of Vital Records.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 23, 2011 Marie Kuzsma 7:05P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Senator Bob Hooper Hospice House Forest Hill Harford 8. Date of Birth (Month, Day, June 2, . Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthdav 9. Birthplace (State or Foreign Days Hours 155–10–2289 New York **Director** 93 1918 1 ☐ M 2XXF Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Harford 1 Yes XX No Havre de Grace 10e. Street and Number 10g. Citizen of What Country? , or items 23a 116 Southway Drive 21078 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2X No Specify: "natural" 3XXWidowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Locative of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event; the Maconce. Elementary/Secondary (0-12) College (1-4 or 5+) Medical Secretary Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen Bednarz Catherine Witko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Thomas Kuzsma / Son 116 Southway Dr. Havre de Grace Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Dec. Date 30, 1 Durial 2 Cremation 3 Kemoval from State Prospect Hill Cemetery 5 Other (Specify) 2011 Flemington, New Jersey 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 21. Signature uneral Service License 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sici_n disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy or Attending Physician: The perform 1 Yes 2 No 1 Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Certificate: To Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (S 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Tes 2 No Investigation within 24 hours after death To the Funeral Director: / 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 29d. Date signed (Nonth, Day, Year) ĺθ who completed cause of death (Item 23a) (Type, Print) 30. Name and ad 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Kimberley Loeblein Kidd 2011 9:15 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harrford 806 Whitaker Mill Rd Jappa Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country)
 Baltimore Min. Hours 212-76-5414 1 🗆 M 2 🔀 F **Director** 50 Aparil 16, 1961 Maryland Usual Residence of Decedent 28a-f shov 10a State items 23a or 28a-f sho er must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Jappa 1 - Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 806 Whitaker Mill Rd. 21085 U.S.A. 11. Marital Status Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Yes 2 X No Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Program Assistant — CCBC Essex Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George J. Loeblein Laverne D. Loeblein (nee Paladary) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 Whitaker Mill Rd. Joppa, Maryland 21085 Mr. Brian Kidd (Scouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State cemetery, crematory or other persons Funeral Chapel Bel Air 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee Testerman 22 Name and Address of Facility Fivans Funeral Chapel & Cremation Services - Bel Air (M01543) 3 Newport Drive, Forest Hill, Maryland 21050 Jeffrey R. (MO1543) 23a. Part 1 Inter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_{si}i.n disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed Yes 2 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death n 24 hours after death.

• Funeral Director: After the bletely filled in by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print State DEC 27 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Catherine Kavoures Physician/ 2011 6:45 A M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Bethesda 4c. County of Death Examiner Suburban Hospital Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Numbe 033-12-1409 **Funeral** Months Days Hours Min. 88 **Director** 1 □ M 2 🎗 F Yrs. 06/20/1923 unkn. 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location notified at Director Silver Spring MD Montgomery 1 X Yes 2 □ No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code "natural", or items 23a or 20906 Funeral 13106 Wilton Oaks Drive 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced A and Mental Hygiene.

27 is marked other than "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Federal Government Secretary Be 17. Father's Name (First, Middle, Last) Nother's Name (First, Middle, Maiden Surname)
 NICHOTA KOMINIS permit. Page 1 and 2 should be file Department of Health and Mental Inportant: If item 27 is marked o any injuy or other traumatic eve once. Nicholas Kavoures 19a. Informant's Name/Relationship (Type, Print)
Nicholeta K. Straub / Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13106 Wilton Oaks Drive, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗆 Burial 2XXCremation 3 🗆 Removal from State 12/23/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Prota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Marsha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ms. Approximate Carroted Struce Onset and Death Immediate Cause (Final Internal Physician/ disease or condition resulting in death) Medical Due to for as a consequence of Examiner Pestension naut Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence a) sician and burial-transit IIdeath certificate be executed ahe that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical men tra. use a: IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? page 2 should be detached for Day g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ohe touchue 04300 e • 1 □ Yes Records, 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv perform 1 ☐ Yes 2 ☐ No Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 21 No Hospital Other: 1 🗌 Yes ER/Outpatient 3 DOA 2 1 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death of 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rochalle, Tures oaks Blud State Registrar

11-07013
Wesley Kyser

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Vesley Kyser	State of Maryland / Department of Health and Mental Hygiene 1-For State RegIstrar Certificate of Death Reg. No.	1 4132
Physician Medical Examine	n/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death	3. Time of Death 2030 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Tate Road 4c. County of Death Calvert	h
Funeral Director		
and show any necs.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location unk unk	10d. Inside City Limits 1 Yes 2 No
eath with the Maryland items 23a or 28a-f sho ust be notified at once, uneral Director	10e. Street and Number unk unk USA	intry?
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once leted by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Ame White, etc.	rican Indian, Black, Thite
	3	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Elementary/Secondary (0-12) College (1-4 or 5+) 2 17. Father's Name (First, Middle, Last) Russell Howard Kyser Tob. Decedents Susual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 18. Mother's Name (First, Middle, Maiden Surname) Eleanor M. Jackson	ulik
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 3054 Greenhaven Court Ellicott (
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and M Important: If item 27 is no injury or other traumaric	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City of Cremation 3 Removal from State crematory or other place)	
Balt permit. Departu Import injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Thomas Allen PA 7090 Ridge Rd Ha	nover MD
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Could Not Be Determined Due to (or as a consequence of):	Approximate Interval Between Onset and Death
	Sequentially list conditions, b	
nuted ransit Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
50, te be executed tysician and burial - transit		
b. Box 6876(the death certificate the attending phy ched for use as the b Physician/Me	The FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 23d. Date of deliver Month 27d. Date of deliver Month	y Day Year
ires that the signed by the detached	1 Yes 2 No 3 Pro	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – trans edical Certification: To Be Completed by Physician/Medical E		utopsy findings available completion of cause of es 2 No
F Vital Physician r this cert al director	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other	r: Scene
Division of N spiral or Attending Ph. rours after death. neral Director: After it filled in by the funeral Certification: Tr	27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 1 Yes 2 No 28d. Describe how injury occurred 1 Yes 2 No 28d. Describe how injury occurred 1 Yes 2 No 28d. Describe how injury occurred and Double Number City	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the ledical Certificatif	29a. Cerimer .	Md.
To the Hos within 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	ne cause(s)
	Ca Called O.C.M.E. November 22, 2	
	30. Name and address of person who completed cause of death (Item 23a) Zabíullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registra		

Kahler Charles

			Pleas	se Type or Pri						_	ble.		
			For State	State of M	aryian		tificate of l			0.0	1.1	1.1327	
			Registrar 1. Decedent's Name (First, Middle,	Last)		Oei	incate of t	Jean	2. Date of Dea	th	-	3. Time of Death	
	Physicia Medic		Charles P. Kah	ler					Month	and a	Year OII	350 PM	
Se Co	Examin		4a. Facility Name (if not institution,	give street and number)			4b. City, Town, o	r Location of Deatl	4c. County	of Death			
A STAN	# 		Franklin Sq	yare HOSF			Rosec		Long con	Baltimore			
10	Funeral Director		5. Social Security Number 215-03-5499	6. Sex 7. Ag	e (In yrs. 18 93	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(Year)	lace (State or Foreign ry)		
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	ryland -f sho ied at	ctor	10a. State 10b. County	Balto.	10c. City	y, Town or Loc F	cation Parkville				10	0d. Inside City Limits	
	ne Ma or 28a notif	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Coun	1 ☐ Yes 2 💢 No	
	with ti	Funeral	8810 Walther Bl	vd. Apt.15	02		212	.34		USA		,.	
	items		11. Marital Status	12. Was Decedent I		S. 13. V	Vas Decedent of H	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No-		- America		
36	after or vamir	d by	1 ☐ Never Married 2 ☐ Marrie 3 🕱 Widowed 4 ☐ Divorced	If Yes, Give	No	1	☐ Yes 2 X No			Specify:	Whi		
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Completed	15. Decedent	Year or Dates.			lent's Usual Occup			16b. Kind of Bu			
215	in 72 e. han "r	dwo	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4 or 5	ō+)	life. D	O NOT use retired)	during most of wor				,	
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anc	be filed within ental Hygiene. ked other tha ic event, the N	To E	Adam E. Kahler	ist)				Emma Ki	ne <i>(First, Middl</i> e, <i>l</i> 1fay1e	Maiden Surname,			
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	g Address (Street	and Number or Ru	Rural Route Number, City or Town, State, Zip Code)				
	id 2 st salth a n 27 it		Mary E. Schultz	DT	R.	1	-	Estates		kville,			
Baltimore,			20a. Method of Disposition 1X Burial 2 Cremation	3 ☐ Removal from State	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other place ark	ce)	Date	20c. Location -	-	wn, State	
ţi	. Pag tmen tant jury		4 Donation 5 Other (Sp	pecify)	Lou				7-2011	Balto.			
Bal	permit. Departr Imports any inju		21. Signature of Funeral Service Li	pensee		- 1		ss of Facility Sc		Funeral ham, Md			
			23a Part 1. Enter the disease, or control shock, or heart failure. List of	pmplications that caused	the death		9705 $Be1s$ or the mode of dying					Approximate	
-F	Physician/		Immediate Cause (Final disease or condition	0								Interval Between Onset and Death	
and the same	Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):	Shock						
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09	the Hospital or Attending Physician: The law requires that the death certificate be hin? A hours after death. The St. hours after death. The st. hours after death. The st. hours after death. The st. hours after death. The st. hours are st. the the st. hours are the st. hours and the st. hours are the st. hours and the st. hours are the st. hours are the st. hours are the st. hours are the st. hours are st	dical		d							\dashv		
Box 68760	requires that the death certificate to been signed by the attending phys should be detached for use as the	Physician/Medi	IF FEMALE;	23c. If yes, outcome	of pregna	ncv				22d Dat	a of dollar		
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Vit	Physicia this cer ral direc	To B	examiner? 1 res 2 No	Hospital:	ent 2 🗆	ER/Outpatier	l ou	or	lome 5 Resid	ence 6 🗆 Othe	r (Specify)		
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sior	Attend death ctor: / cy the	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	ot be	inv - At ho	me farm stre		Yes 2 No	28f Location /S	treet and Numbe	r or Rural	Route Number	
Division of Vital Records,	al or / s after al Dire		4 ☐ Homicide determin	building, etc			, ,,,		City or Town		o, 110701	, , , , , , , , , , , , , , , , , , , ,	
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical		Physician: To the best of aminer: On the basis of e									
	the lithin 2 the lomble	Me		Nurse Practitioner: To th				the time, date and p	olace, and due to the		anner as s	tated.	
	70 Wit		1 Alona	2 hinds))	2/3	2011	
	15		30. Name and address of person w	ho completed cause of d	eath (Item	23a) (Type, P				1000	<u> </u>	Ø UII	
-	10		Dr Alexis Da	vis 9000 Fr	anki	in Sq	vale Dri	ve Bost	imose, M	10 212	3.7		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Denise Loiseau Month PM Marie DECEMBER 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DUSON SAINT JOSEPH MEDICAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Haiti 7. Age (In vrs. last birthday) **Funeral** O 7 O 7 090-34-5517 Days Hours **Director** 1 □ M 2**X** F 79 or 28a-f show notified at 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Director Lutherville 1 Yes 2 XNo MD Baltimore ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 21093 U.S.A. 7 Tenburg Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, e þ 1 Never Married 2 Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Haitian 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within (21), hand Mental Hygiene.
27 is marked other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mayfair Nursing Home Registered Nurse 2th grade 8yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frances Patrick O'Neil Laura Joseph other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10506 Long Branch Road, Cockeyville, 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or Att Cassandre Epps-Daughter 1030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/29/2011 Towson, Prospect Hill Donation 5 Other (Specify) 21. Si ature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or head failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final MULTIPLE Ph_si_ian/ SYSTEM ORGAN FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami PULMONARY EMBOLUS MASSIVE that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the attending properties as E FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death the g Unknown g | I Inknown Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ POST CHRDIAL ARRESTS Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? ANOXIC ENCEPHALOPATHY 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 🔀 Natural iniury work? 5 Pending ieral Director: Af rilled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical within 24 hound to the second 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: Te the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month. Day, Year) 403 30. Name and address of person who completed car e of death (Item 23a) (Type, Print) 7601 DRIVE m.D. TOWSON MARYLAND OSLER

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Charles umb 00:20 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center Ballimoro University (Horslan N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Min. Director 219-30-1576 1 **X**M 2 □ F 75 Usual Residence of Deceden Jan. 5. 1936 Maryland show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 🗷 No Maryland Caroline Goldsboro 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 23a Funeral 15039 Jarrell Road 21636 items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ö 1 Never Married 2 Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Schould be filed within 72 h and Mental Hygiene. 7 is marked other than "r Consolidated Elementary/Secondary (0-12) College (1-4 or 5+) 12 N/A Freightways Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Newman Lumb Mabe1 Fio1 other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is. Eric M. Lumb (Son) 15039 Jarrell Road Goldsboro Maryland 21636 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremation 12/30/2011 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ hemosthage disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Ltrans Due to (or as a consequence resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No Unknown signed by t Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Physician: The Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No М filled in by the Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 139 6868 281 30. Name and address of person who completed cause of death miversity

Registrar DHMH 17 Rev 06-2011

State

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 0500 PM 12 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner attimore Old Court 3.10 If Under 1 9. Birthplace Country) last birthday) **Funeral** Year) 1□ M 2 F Months Days Yrs 212-34-3603 Usual Residence of Decedent Director 3603 b North 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Funeral Director sville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with Was Decedent Evo Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 ☐ Divorced ac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me /Secondary (0-12) College_(1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (\$13467) Balto. trea MD OXanne 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or 2 Cremation 3 Removal from State 4 □ Doylation 5 □ Other (Specify) 21. Signa Funeral Service Licensee Name and Address Hom, P.A. North Approximate Interval Between Onset and Death 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Immediate Cause (Final Physicia<u>n</u> disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of): P.O. Box 68760. led by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day in the past 12 mo 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9∏Unknown 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u>Ş</u> 2□ No 3 Probably 1 | Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No certificate 2 No 1 ☐ Yes 1☐ Yes Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After (Month, Day Year) 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Neertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

BV

State Registrar 31. Date filed (Mont

DEC 2 7 2011

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Willi R. Linde December 23, 2011 Physician/ 5:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Perry Hall 4213 Silver Spring Road 7. Age (In yrs. last birthday) 82 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Germany **Funeral** 1 ★ M 2 □ F 02708/1929 **Director** "natural", or items 23a or 28a-f show idical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore 10c. City, Town or Location 10d. Inside City Limits Director Perry Hall 1 🗌 Yes 2 💢 No 10f. Zip Code 21128 10e. Street and Number 4213 Silver Spring Road 10g, Citizen of What Country? Funeral Germany 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Engineer Be 17. Father's Name (First, Middle, Last) Albert Linde 18_Mother's Name (First, Middle, Maiden Surname) Franziska Karjan ၉ 19a. Informant's Name/Relationship (Type, Print)
Elisabeth Linde / Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Silver Spring Road, Perry Hall, MD 21128 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Chesapeake Crematory 12/26/2011 Beltsville, MD 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility mation Services PO Box 1413, Baltimore, MD 21203 W-lla 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ di-souse 61-6 a Comprom disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Atrial tierilletion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine Due to (or as a consequence of): that the death certificate be executed burial-transit Hyportonsion and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No 2 No Yes Division of Vital funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 12/23/11 H. Keln MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21236 BRIAN 31. Date filed (Month) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George Robert Lott Month 12 2:35 AM 201 Medical 4a. Facility Name (if not institution, give street and number)
Meritus Medical Center 4b. City, Town, or Location of Death Examiner County of Death Washinton Hagerstown Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 5. Social Security Number 077 – 18 – 7367 Country) NY 1**X**X M 2 □ F 86 02/22/1925 Director Usual Residence of Decedent 10c. City, Town or Location Hagerstown 28a-f show Washington within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 XNo ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21742 19747 Tranquility Circle items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1XX Yes 2 NoNa vy permit. Page 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or if
any injury or other traumatic event, the Medical Examine
once. Black, White, etc. Completed by 1 Never Married 2 X Married 1XX Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates. 1943-46 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Design Engineer Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Lott Alice Lamaire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Alice Lott / Wife 19747Tranquility Circle, Hagerstown, MD 21742 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State Chesapeake Crematory 12/27/2011 Beltsville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baitimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ASPIRATION MEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) . Examiner HTPO + EMIA Sequentially list conditions, Examiner cause. Enter Underlying LGU CO 67 1051 J Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Completed by Physician/Medical D118555 MELLINS Division of Vital Records, P.O. Box 68760 es, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPORCANBIA 1 Yes 2 No 3 Probably 4 Unknown HTPORNATION IN Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy performed? Yes 2 N death? AZOTOMIN 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Certificate: To 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Accident 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 00062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALTAKO-WIRSONY 11116 m GOICE HAGERSTOWN, MO compus

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month; Day, Year)

Please Type or Print in Black Indelible 19k8 Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER Day 20 2011 Рм 7:20 LANEY LOUISE ELLA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deatl PRINCE GEORGE'S UPPER MARLBORO 17111 CLAIRFIELD LANE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min MAYnth, 279, 19941 KENTUCKY 1 M 2 -60 70 579-54-2659 Yrs Director Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at rector PRINCE GEORGE'S SPRINGDALE MD 1X Yes 2 No 百 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 USA 4011 91st AVENUE death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. BLACK þ 1 Never Married 2X Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE HOMEMAKER 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ MAE U. PRENTICE ROY CRAIG 19a. Informant's Name/Relationship (Type, Print) a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

FREDERICK DOUGLAS LANEY/HUSBAND 4011 91st AVENUE SPRINGDALE, MARYLAND 20774 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State RIVERDALE, MARYLAND RIVERDALE CREMATORY 12/22/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Exter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart a ure. List only one cause on each line. Immediate Cause (' i al disease or indition Onset and Death Phylician MULTIORGAN FAILURE Medical resulting in death) Due to (or as a consequence of): Examiner METASTATIC CANCER Sequentially list conditions, Examine If any leading to immedicause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsequence of) burial-transi LUNG CANCER and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate beithin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis COLON CANCER P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached for g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records. 1X Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 64 Other (Spec 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 21, 2011 D45630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARNULFO BONAVENTE M.D. 6409 S. CRAIN HIGHWAY UPPER MARLBORO, MARYLAND 20772 31. Date filed (Month, Day, Year) State 2 DEC Registrar

DHMH 17 Dev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 12/19/2011 Physician/ Leo LoSchiavo 11:33p ^M Medical 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel 4a. Facility Name (if not institution, give street and number) **Examiner** 1461 Pleasant Lake Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 578-30-6382 84 02/19/1927 1 XM 2 □ F Wash D.C. **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at Director 1 ☐ Yes 2X No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 23a 21409 1461 Pleasant Lake Road or items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. 1X Yes 2 No
If Yes, Give 1945-46
Year or Dates. þ 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 Yes 2 XNo Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Dept of Navy Accountant 5+ of Health and Mental Hyg item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Giovonna Crupi Teodoro LoSchiavo should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1461 Pleasant Lake RD Annapolis MD 21409 Robert G LoSchiavo Son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Atlantic Crem 1 Burial 2X Cremation 3 Removal from State 12/22/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv Signature of Juneral Service Licenses ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death PRUSTATE CANGER Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

☐ Consequent et time of death 5 ☐ Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Year Day 1 Yes 2 L 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 🗌 Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 2 No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 7. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely only one) 29c. License number 0 6 785 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of 12/20/2011 MEDICAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOUT GANG

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 20, 2011 5:45 P M Henry John Lang, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lutherville Baltimore College Manor 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday, **Director** 218-18-3500 1 X M 2 G F 1/6/1925 Maryland 86 or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Maryland Carroll Westminster 1 Yes 2 No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral U.S.A. 520 Portias Delight Drive 21158 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?
1 □ XYes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Wildowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Sheet Metal Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Henry John Lang, Sr. Catherine Landefeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip_Code) Parkton, Maryland 21120 16904 Prettyboy Dam Road H. John Lang / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 12/23/2011 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) dementes Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Live Birth ∠ ☐ Fetal 300... ☐ Pregnant at time of death Month Day signed by the at d be detached f 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 1 Yes 2 No funeral director, 25. Was case referred to dedical Be 26. Place of Death (Check only one) examiner? Hospital assession Other: 2 No 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manna of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural within 24 hours there....
To the Funeral Director Aftr 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Norse Practitions To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Norse Practitioners 29b. Signature a D24121 30. Name and address of person who completed cause of death (Item 23a) ype, Print) ROSFNBERG Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.,	1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene	4
Cortificate of Death	

			Pleas  1 _ For State	e Type or Print in E State of Maryland	d / Depa	artment of	Health :				gible.	4133
	Physicia		Registrar  1. Decedent's Name (First, Middle, L.  Yun Lee	ast)	Cer	tificate of	Death		2. Date of De	Dav	2 ^{Year} 1	3. Time of Death
	Medic Examir		4a. Facility Name (if not institution, gir Gilchrist	/e street and number)	·	4b. City, Town, Columbi		of Death	Decemb		ty of Death	4:18 P ^M
	Funeral Director			Sex 7. Age ( <i>In yrs. Ia</i>	st birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da		Country	korea
e Maryland	r 28a-f show notified at	Director	10a. State 10b. County  MD Baltimor		, Town or Loc	e					10	d. Inside City Limits 1  Yes 2 No
leath with th	items 23a o	Funeral	10e. Street and Number 1505 N. Rolling 11. Marital Status	Road #218  12. Was Decedent Ever in U.S Armed Forces?		10f. Zip Code 21228  Vas Decedent of Frest, specify Cub	Hispanic Orig	gin? (Spe	ecify Yes or No-		ace - America	ı Indian,
-0036	natural", or ical Examin	leted by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1	Yes 2 XN	Specify:	, Fuerto	nican, etc.)	Black, White, etc.  Specify: Asia  16b. Kind of Business/Indus		
<b>CLZLZ L C C L Z L Z L Z L Z L Z L Z L Z L Z L Z L Z L Z L Z Z L Z Z Z Z Z Z Z Z Z Z</b>	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4 or 5+)	(Give H	kind of work done NOT use retired Employed	during most			Sales		Isury
arylanc hould be file		To B	<ul> <li>17. Father's Name (First, Middle, Last</li> <li>Soon Kook Lee</li> <li>19a. Informant's Name/Relationship</li> </ul>		19b. Mailin	g Address (Street	Sook	You	ng Kong		or Town, State, Zip Code)	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after	t of Health a If item 27 is or other tra		Sung Lee  20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3	/ SON 20b. Pl	3338	Hollow C sition (Name of natory or other pla	Court;	E11		-	21043	3
<b>Baitim</b>	Departmen Important: any injury once.		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funer 7 Strict) Lice	city) Dula	22	ley Mem Ga . Name and Addre ck Towsc	ess of Facilit	у		1	L050 Yo	ork Road MD 21204
	ynician/ Medical		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death one cause of each line.  a.  Due to or as a consequence.	Do not ente		ng, such as				, I	Approximate nterval Between Onset and Death
	attending physician and if or use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)  C. Due to (or as a consequence)  d.	,							
LIVISION OF VII. DECORDS, F.O. BOX 06/00 the Hospital or Attending Physician: The law requires that the death certificate be executed	/ the attending phy ched for use as th	by Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnar	су				ate of delivery	/ ay Year
dS, P.O	been signed by the s should be detached	ted by Pl	Part II. Other significant conditions	contributing to death but not resu	ılting in the u	nderlying cause g	iven in Part I		23e. Did to			cause of death?
in: The law re	ate has page 2	e Completed	25. Was case referred to medical			26 5	lace of Deat	h (Chaol			Were autops prior to compleath?	y findings available bletion of cause of
DIVISION OF VICAL RECORDS, all or Attending Physician: The law requires	s after death.  I Director: After this certific ed in by the funeral director,	Certificate: To Be	examiner? 1 ☐ Yes 2 M No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigatic	(Month, Day, Year)	ER/Outpatien 28b. Time of injury	t 3 DOA Oth	ner: 4 □ Nu ry at	rsing Ho	me 5 🗆 Resid	dence 6 Otl		nospie
DIVISIO	urs after de ral Directo illed in by th		3 Suicide 6 Could not 4 Homicide determined	building, etc. (Specify)				d	City or Tow			
To the Hosp	within 24 hours after <b>To the Funeral Dire</b> completely filled in b	Medical	(Check 2 L Medical Exar	ysician: To the best of my knowle niner: On the basis of examination urse Practitioner: To the best of m	and/or investi	igation, in my opini	ion, death oc the time, dat	curred at	the time, date a ce, and due to t	nd place, and di he cause(s) and 29d. Date signe	ue to the cause manner as sta ed (Month, Da	e(s) and manner stated ted. y, Year)
			30. Name and address of person who	completed cause of death (Item 2	23a) (Type, Pi	rint) CA	sez	03		Decen	nber 2	0
	Stat Registra	_	31. Date filed (Month Day Yea)	32. registrar's Signatu		ale	- 100	/ 3	<u> </u>	JW 30-	0 100	1)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Pear DECEMBER 22 2011 Physician/ 03:00A M CYNTHIA LANDAU Medical 4c. County of Death a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Davs Hours (Month, Day, Year) 12/05/1915 96 Yrs OH Director 578-46-9289 Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No SILVER SPRING MD MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be n Funeral 8911 GLENVILLE ROAD 20901 ural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced "natural", Completed WHITE the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) PERSONNEL SUPERVISOR RETAIL permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ BENJAMIN MICHAELSON KATIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4117 SANDCASTLE LANE, OLNEY, MD 20832 LEE LANDAU / SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEM. GARDENS 12/23/2011 OLNEY, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Juneral Service Licer Latt 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph sician/ MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ONGESTIVE HEART Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate | 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?

1 
Yes Other: 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 6 \( \sum \) Other (Specify) 2 1 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | Medical Examiner. On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 | Medical Examiner. On the basis of examination and/or investigation, in my occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 68005 DECEMBER, 22, 2011 Destract MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AVENUE, TAKOMA PARK, MD 20912 JENNIFER DBIADI mD 31. Date filed (Month, Day, Year) 22. Registrar's Signature.

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar 4 1 3 3 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 6:40 PM Mayhorne Jr. Davis Medical December 21, 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min Director 219-32-4274 1 X M 2 🗆 F Feb 20, 1937 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Baltimore Dundalk 10e. Street and Number 9 10f. Zip Code 10a. Citizen of What Country? the Medical Examiner must be Funeral 23a 9 German Hill Rd. 21222 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Oil Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Davis Mayhorne Sr Irene Bundick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 si tment of Health a Irene McAree /Sister 9112 Deviation Rd. Nottingham, MD 21236 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place Dec 4 Donation 5 Other (Specify) Chesapeake Crematory 2011 Beltsville, Maryland 21. Signature of Funeral Service Licensee 106585 22. Name and Address of Facility Cremation and Funeral Alternatives Hocker 8717 Green Pastures Drive Towson Mary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) YEAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician by Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death
Unknown Month Day Year 1 ☐ Yes 2 ☐ Unknown detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 065Muchne 1 Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an aw autopsy or Attending Physician: The this certificate 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred After iniury 5 Pending work? 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

21215-0036

Baltimore, Maryland

Box 68760

Records,

of Vital

Division

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year

**DEC 27** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HALVES

32. Registrar's Signature

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 21)( 1810 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) Social Security Number 212–28–9264 7. Age (In yrs. last birthday) **Funeral** M 2□F 79 Director Feb 11, 1932 Maryland 23a or 28a-f show st be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Pasadena 1 🗆 Yes 2 🏝 No Anne Arundel the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 141 Dunlap Road with "natural", or items 23a USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Never Married 2 🗓 Married X Yes 2 No by Maryland 21215-0036 1 Yes 2 No Specify. Specify: White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry n and Mental Hygiene.
7 is marked other than "i Elementary/Secondary (0-12) Plant Manager Ennar Latex Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Alvin Myers ပ Anne Hutson pe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Jennelea Myers 141 Dunlap Road, Pasadena, Maryland 21122 (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/31/2011 Glen Burnie, Maryland Glen Haven Merr. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Signature of Funeral Service Licensee Kevin E Ecker any in once. MO0175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each. Immediate Cause (Final Physician EMEN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' After this certificate 1 ☐ Yes 2 ☑ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 Natural 5 Pending 2 Accident Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi 29c. License number Date signed (Month, Day, Year) ecenhu 204 ted cause of death (Item 23a) (Type, Print) Name and address of person who come

DHMH 17 Rev 06-2011

State Registrar MILHAR

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41340 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Henry Joseph Mielke 5:37 P M December 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Sykesville 4c. County of Death Brinton Woods Health Care Center Social Security Number 6. Sex 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 213-36-0215 07/27/1939 **Director** 72 MD 1 XM 2 □ F Usual Residence of Decedent 28a-f shov 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Finksburg 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 1506 Marie Drive 21048 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: and Mental Hygiene. is marked other than "natural", Specify: White 3 X Widowed 4 □ Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Moving Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry Mielke Virginia Grove Page 1 and 2 should nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Molly Bever / Step-Daughter 1506 Marie Drive, Finksburg, MD 21048 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Chesapeke Crematory 12/27/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall Maryland Cremation Services PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Beath shock, or heart failure. List only one cause Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ detached for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the funeral director, page 2 should be Unknown 1 Yes 2 No 3 Probably certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) √anner of D ath Certificate: 28h. Time of s after death. 28c. Injury a 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completely (Check 29b. Signature and title of certific License number no 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) Ma 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

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Baltimore, oermit. Page 1 and	Important: If iter any injury or oth				☑Removal from St	tate c	Place of Disp cemetery, cre imanja	matory or c	other plac		Ja:	Date n. 2, 012	Ki]	_{-ocation} . Limar ızani	njaro	Town, State	Moshi	. ,
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Division of Vital Records, P.O. Box 68760 tall or Attending Physician: The law requires that the death certificate be ris after death.	To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu		F FEMALE: 23b. Was decedent   in the past 12 n 1  Yes 2  9 Unknown	nonths?		rth 2  Feta Int at time of c	al death 3	☐ Ectopic   ☐ Other (sp		су				23d. Da	ite of del		Year	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 22 ^{Day} 011 9:35P Dec James L. McCart 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Bonds Forest Assisted Living Carroll Finksburg 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign MD Country) 7. Age (In vrs. last birthday) 1 🔀 M 2 🗆 F Days Hours (Month, Day, Year) -19-1924 215-14-9646 87 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Lee Cape Coral 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5703 Flamingo Dr. 33904 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
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Yes 2 □ No Black, White, etc. 1 Never Married 2 Married If Yes, Gi 1 ☐ Yes 2 X No Specify. Specify: White 3 ☐₩Vidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Engineering Elementary/Seconday (0-12) College (1-4 or 5+) Engineer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Bernhard James L. McCart 19a. Informant's Name/Relationship (Type, Print) Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Deer Park Rd., Westminster, MD 21157 Casimir P. Saintcross 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Evergreen Memorial 12-28-11 Finksburg, MD 21. Signatura of Juneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home, lephu III Z 254 E. Main St. Westminster, MD21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only o Immediate Cause (Final disease or condition arterioscleration resulting in death) Due to (or as a consequence of): Vascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ementa Due to (or as a consequence of): 3d. Date of delivery Month Day Year e contribute to the cause of death? 🖟 No 3 🗌 Probably 4 🗌 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

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To the Funeral Director: After this certificate has been signed by the attending physicia

Division of Vital Records, P.O. Box 68760

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1   Live Birth 2   Fetal death 3   Ectopic pregnancy  4   Pregnant at time of death 5  Other (specify)    9   Unknown	23d. Date of delive
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to th
		24a. Was an autopsy prior to corperformed?  1 ☑ Yes 2 ☐ No 1 ☐ Yes
25. Was case referred to medical	26. Place of Death (Check on	ly one)
examiner? 1  Yes 2  No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year) injury work?  M 1 ☐ Yes 2 ☐ No	. Describe how injury occurred

Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 'Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) ideleton

Registrar

31. Date filed (Month, Day, Year)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 343 = State Registrar Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death Physician/ December 22, 2011 11:40 A. M Emil Vincent Morisi Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Towson Gilchrist Hospice Center Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** April 13, 1943 Days Maryland 68 Director 217-40-5634 1 🕱 M 2 🗆 F Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Harford Bel Air 1 🗆 Yes 2 🔀 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21015 United States 1526 Parkland Drive death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, e 1 Yes 2 No
If Yes, Give
Year or Dates. "natural", or þ 1 Never Married 2 X Married White within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the Engineering Saleman 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Madelyn Spinosa Henry Morisi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21015 19a. Informant's Name/Relationship (Type, Print) 1526 Parkland Drive Bel Air, Maryland Terry Morisi / Spouse If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of F Important: If ite any injury or otl Dec Date 28. 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Highview Memorial Gari 2011 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature uneral Service Evans Funeral Chapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (o **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ jo in the past 12 months? Month Year Pregnant at time of death signed by the a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Af
d in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hound to the second 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on nd title of certifier Signatu 29d. Date signed (Month, Day, Year) D0071287 12-22-11 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Subtractions of person who completed cause of death (Item 23a) (Type Print) Subtractions of person who completed cause of death (Item 23a) (Type Print) 10 ,6701 N. Charles State Registrar

			_ For	State of Mary	land / Depa	ırtment of H	Health and N	-	giene					
		_	1 - State Registrar	1	Cer	tificate of L	Death		Reg. No. 20	110				
	Physicia Media	cal	1. Decedent's Name (First, Middle, Last, Gregory Park M.	akin				2. Date of Dea Month December	er 24, 20					
	Examir	er	4a. Facility Name (if not institution, give s Gilchrist Care Ce	,		4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore								
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h	9. Birthplace (State or Foreign Country)Baltimore				
	Director		217–64–2077  Usual Residence of Decedent	<b>X</b> M 2 □ F	46 Yrs.	, 1965 M	Maryland							
	land show dat	tor	10a. State 10b. County	100	c. City, Town or Loc	cation		<u> </u>		10d. Inside City Limits				
	e Mary r 28a-i notifie	Director	Maryland Harford	B	el Air	Troi 7: 0 1				1 ☐ Yes 2 🔀 No				
	with the 23a or		10e. Street and Number  304 Wakefield Dr.			10f. Zip Code 21014			10g. Citizen of Wh	nat Country?				
	items	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?			ispanic Origin? (Sp an, Mexican, Puerto			- American Indian,				
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.		☐ Yes 2 <b>X</b> No		1110411, 010.7	Specify:	, White, etc. White				
2-0	2 hour "natur edical	Completed	15. Decedent's Edi (Specify only highest grad	ucation		ent's Usual Occup	ation during most of work	ina	16b. Kind of Bus	iness/Industry				
121	ithin 7 ene. r than the Me	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DC	NOT use retired)	erground Gas		BGE — Ut	rilities				
d 2	filed wall Hygi I other vent, i	Be	17. Father's Name (First, Middle, Last)		1				Maiden Surname)					
ylaı	Menta	으	Ned P. Makin				Dona L. I	Bender						
Baltimore, Maryland 21215-0036	12 shou alth and 27 is n r traum	3	19a. Informant's Name/Relationship (Type Mrs. Tracy Makin (Sco			_	and Number or Rur <b>Dr. Bel Air</b> ,		-	ate, Zip Code)				
ore,	of Hee		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ I	Pernoval from State	0b. Place of Dispos	sition (Name of	(e)   Dec	Date	20c. Location - C	City or Town, State				
ţi	permit. Page 1 a Department of I Important: If its any injury or ot		4 Donation 5 Other (Specify)		vans Funera Bel Air					l, Maryland				
Ba	Depar Impol any ir		21. Signature of Funeral Service License		nsterman 22 1543) 3	Name and Address Vans Funera	s of Facility I Chapel & rive, Forest	Crematic	n Services	- BelAir				
П		П	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	ications that caused the e cause on each line.						Approximate Interval Between				
	hynician/	K 4	Immediate Cause (Final disease or condition		-750m					Onset and Death				
Minis	Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):									
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Box 68760	ath cer attendi for use	Physician/Medic	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date Mont	of delivery th Day Year				
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A	At home, farm, stre			28f. Location (S		or Rural Route Number,				
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	6		30. Name and address of person who co	mploted sauce of doubt	(Itom 22a) (Time 2	int)	5 0C Q	)	Decemb	24 2011 10				
	C		AAUN 1 CAM		(item 23a) (lype, Pl	71 N. C.	nunls s	- Ten	SON N	20				
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		For State	State of Mar		artment of			2.0	11 413	45			
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Examin	er	Casey House	re street and number)		Rocky	or Location of Deat	tn	4c. County of Montgo					
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ith the 3a or t be n	Funeral Director	10e. Street and Number	7.13		10f. Zip Code			10g, Citizen of Wha	-				
ems 2	nue	10500 Rockville	P1Ke #G15  12. Was Decedent Eve	er in U.S. 13, V		852 Hispanic Origin? (S	Specify Yes or No-	United S	American Indian,				
fter de , or it amine	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give		f Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	Black, 1	White, etc.				
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ould b nd Mer mark matic	ľ	Joseph Ramoska  19a. Informant's Name/Relationship	(Tyge, Print)	10h Mailir	on Address (Street		e Philli	ps r, City or Town, State	e Zin Codel				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		Gloria Borer / D						-	uesda, MD 208	352			
of He of He If item		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	Ramoval from State	20b. Place of Dispo			Date	20c. Location - Ci					
t. Pag tment rtant: njury o		4 Donation 5 Other (Spe	cify)						, Maryland				
permit Depar Impor any in		21. Signature of Funeral Service Lice	Hechrotk	MO1251 B	Name and Addre Ding Home Everly L	ess of Facility Cremati • Heckrot	ion Servi te, P.A.	ice P.O. I Clarksv	Box 784 ille, MD 210	29			
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certification iding partitions is as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				23d. Date of	of delivery				
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ding F h. After t funer	:ate:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Y	(ear) 28b. Time of injury	28c. Inju wor M 1 [		28d. Describe h	ow injury occurred					
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Exa	nysician: To the best of my miner: On the basis of exar	mination and/or invest	tigation, in my opin	ion, death occurred	at the time, date a	nd place, and due to	the cause(s) and manner st	tated.			
o the	Ž	only one) 3 Secritifying Nu 29b. Signature and title of certifier	urse Practitioner: To the b	est of my knowledge,	death occurred at		1	he cause(s) and man 29d. Date signed (A		_			
F > F 0		Dalan.	mellos,	CRNP		13201		12/25	:/11				
10		30. Name and address of person who		, , , , , ,	Print)		1		+				
(3		6001 Muncaster M 31. Date filed (Month, Day, Year)			20855	<u> </u>							
Stat Registra		DEC 2 7 2011	32. Registrar's	Signature	,								

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	-	-			nd Me	ntal Hygi	ene	0 1	1	1 1	217	
•			State Registrar			Certifica	te of D	eath			eg. No. 🔼	<u>U I</u>	4	4	34/	
	Physicia	n/	Decedent's Name (First, Middle, Las	t)		11.			2	Date of Death Month	Day Year					
	Medic		Linwood			Morg	ecember	ber 15, 2011 01:18 am								
	Examin	er	4a. Facility Name (if not institution, give	/ , , ,		4b. Cit	y, Town, or	Location of	Death	,	4c. County	of Death	h	1	,	
	<u></u>		5. Social Security Number 6, Se	050000/	(In yrs. last birth	day) If Und	er 1 Year	If Under 24	4 Hrs   6	Date of Birth	1201	9 Rid	boloco (	State or	Foreign	
	Funeral Director		212-58-3418	X M 2 □ F 7. Age		rs. Months				me 30,	Year 953		Try1		Toreign	
			Usual Residence of Decedent	ļ												
	and shov	for	10a. State 10b. County		10c. City, Town										y Limits	
	Maryi 28a-f otifie	rec	MD		Balt	imore							1	Yes	2 🗆 No	
	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 1000 N. Gilmore	C+			ip Code 21217			1	0g. Citizen of USA	What Co	untry?			
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36	after al", o	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates.	No	1 🗆 Yes	2 🕅 No	Specify:			Specify	bla	ıck			
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715	n 72 h an "n Medi	mp	(Specify only highest gra	de completed) College (1-4 or 5	——————————————————————————————————————	(Give kind of w life. DO NOT u	ork done di	uring most o	of working	1			,		1	
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yla	Ild be Ment arke	욘	Linwood Morgan	Sr.												
<u>Jar</u>	sh is au		19a. Informant's Name/Relationship (Ty			Mailing Addre										
e o	and 2 Health em 27 ther tr		Charles Whitlock - 20a. Method of Disposition	brother-	1	706 Per		vania !						4-1-		
Baltimore, Maryland 21215-0036	ge 1 at of the state of or of	1	1 Burial 2 Cremation 3 D	Removal from State		Disposition (No. ), crematory or		e)	Date	9   '	20c. Location	- City or	iown, 5	late		
븚	permit. Page 1 Department of Important: If ii any injury or o	ş	4 Donation 5 Ather (Specific	n state		1		1	Chah	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	D	1				
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			23a Part 1. Enter the disease, or comp	olications that caused	the death. Do no							112		roximate		
ı,			shoek, or heart failure. List only of Immediate Cause (Final				34			33.4			Inter	val Betv et and D	veen	
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		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence o	f):									-	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	Back	40ce	ms										
	exect an an rial-tr	Ë	resulting in death) Last	Due to (or as a	consequence o	f):										
00	cate be executed physician and s the burial-transit	dical		d												
87	tifica ing ph	Me	IF FEMALE:													
Box 687	th cer ttendi	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live Birth	2 🗀 Fetal death			У				ate of del onth	livery Day	V	'ear	
B	the at	Physician/Me	1 Yes 2 No 9 Unknown	4 ∐ Pregnant at 9 ☐ Unknown	time of death	5 Other (	specity)					511611	Duy		ou.	
o.	at the		Part II. Other significant conditions co	ontributing to death bu	it not resulting in	the underlying	g cause giv	en in Part I.		23e. Did tob	acco use con	tribute to	the cau	se of de	eath?	
Records, P.O.	signe d be o	d by	Grabe for							1 □ Ye	s 2 No	3 🗆 Pi	robably	4	Jnknown	
ğ	requi	Completed	W	5107						24a. Was ar	24b.	Were au	topsy fir	ndings a	vailable	
ecc	e law e has ge 2 :	mo	yper ion.	3107						autops perforn	y ned?	prior to o death?	complet	ion of c	ause of	
<u> </u>	n: Th ificate or, pa		25. Was case referred to medical		_		26 Pla	ace of Death	(Check or	1 Yes 2	No	1 Yes	2 🗹	No		
<u>Ita</u>	/sicia s cert direct	To Be	examinef? 1 ☑ Yes 2 ☐ No	Hospital:	nt 2 FR/Out	patient 3 🗆	Othe	r.		5 Reside	nce 6 ☐ Oth	er (Spec	ifv)			
of	g Phy er this ieral o		27. Manner of Death	28a. Date of injur (Month, Day	y 28b. T		28c. Injury	at		d. Describe ho			,//			
o O	ath. r: Aft	icat	1 Natural 5 Pending 2 Accident Investigation		/ea/)	M	work'	r Yes 2□N	No O							
Division of Vital	r Atter ter de irecto	Certificate	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc		m, street, facto	ory, office		28	Location (Str		er or Ru	ral Rout	e Numb	er,	
ó	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit															
	Hosp 24 hor Fune fed fi	Medical	(Check 2 Medical Exami	sician: To the best of a ner: On the basis of ex	amination and/or	investigation, i	n my <mark>opini</mark> o	n, death occi	urred at the	time, date and	d place, and du	e to the	cause(s)	and ma	nner stated.	
	thin 2 the omple	ž	only one) 3 Certifying Nurs  29b. Signature and title of certifier	se Practioner: To the I	est of my knowle		ourred at the 9c. License		and place, a		cause(s) and m			(oar)		
	<b>5 ≥ 5</b> 8		200. Orginal of Columbi	, DMA	11/1	9			55	1					1011	
	<b>-</b>		30. Name and address of person who o	- Completed cause of	ath (Itam 22a)	ivne Print\	00	( / -		1 2	CEN CEN	noe	1	1-	4011	
			30. Ivanistand address or person who c	Meron	11D	200	D W.	Bal	Him.	ore St	. B.	14	mal	20 1	Monda	
	Stat	e	31. Date filed (Month, Day, Year)	32. Registra	r's Sign ture	ha at 1	7.0	- 27 (	A			1.4.1	V - G/	4	a y y corp	
	Registra		DEC 2 7 201	Serve	P. A	aver								_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 2011 Medical 4c. County of Death give street and number, 4b. City, Town, or Location of Death **Examiner** Baltmire Baltmore Honel Therien 9. Birthplace (State or Foreign Country Maryland Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours 01-1860 1 № M 2 🗆 F Director Usual Residence of Decedent f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director Baltimore Baltimore 1 Yes 2 X No 10e. Street and Numbe 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married 1 X Yes Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Letitia G Lyman Richard Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1213 Delbert Avenue, Dundalk Avenue 21222 Nancy Piechocki -Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or otl 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec.27,2011 Baltimore Maryland Woodlawn Cemetery Signature of Fure Service License 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequen Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ence of ď or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or are a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) the a detached 9 | Unknown 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 12 Nursing Home 5 - Residence 6 - Other (Specify) မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 \sum Yes 2 🗌 No Accident Investigation e Funeral Director the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Padical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) မ - MOKRIN

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Anokrin Cert. Nurse Practioner 6811 Campfield Road Baltimore Maryland 21207

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nancy Maria Mullen 11:50 P™ December 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 623 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) **Director** 246-58-9354 70 1 M 2 X F October 16, 1941 North Carolina Usual Residence of Decedent 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Montgomery North Potomac 1 🗌 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral with 14713 Maine Cove Terrace 20878 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) __ 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o James Harrington Lasater Frances Gertrude Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 Department of Health ar Important; If item 27 is any injury or and Thomas F. Mullen/Husband 14713 Maine Cove Terrace, North Potomac, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State December 26 Montgomery Crematorium, Inc. Bethesda, Maryland 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licenses Robert A. Fumphrey Funeral Home/Rockville, Inc. fette M01305 DAMALLA 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, i i n Pusciess Electrical disease or condition resulting in death) Medical Examiner ronar Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) spirator as the burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Month Dav Year the a Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mitrai Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? Encephalopa 24a. Was an ate has page 2 s autopsy performe Hypertension certificate 2 🗌 No 1 🗌 Yes Yes 25. Was cas referred to medical examiner? Hospital or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) D,0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Rockville Dana MD 20850 'e_ DO 31. Date filed (Month. Yei 7 . Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11-0963	9
Jagdish	Mitter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

agdish Mitter		I- For State	of Marylar		rtment of		and	Menta	al Hyg		2 eg. No.	0 1	1 4135	
Physicia	n/	1. Decedent's Name (First, Middle,Last	)	*		_				2. Date of Deat Month	th Day Yea	ır	3. Time of Death	
Medical Examin		Jagdish Mitter  4a. Facility Name (if not institution, give	street and num	ber)	<del>-</del> 14	lb. City, Town	n, or Lo	ocation of I		December	4c. County of	of Death		
		2144 Industrial Parkway				Silver Sp	oring				Montgon			
Funeral		Social Security Number     6. Security Number		'. Age (In yrs. la		If Under 1 Months	Year Days	If Under:	24Hrs. Min.	Forei			n	
Director			M 2 F	71	Yrs		Duyo	.,,,,,,		October	9, 1940	untry) India		
any	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Locati	on							10d Inside City Limits	
. ≸	_	Maryland Montgom	ery			Silv	er :	Sprin	ıg				1 Yes 2 No	
Maryland 28a-f show d at once.	- L	10e. Street and Number				10f. Zip Co				1	0g. Citizen of Wh	at Cour	ntry?	
the h		2300 Fairland Ro					090				United States			
tems 2	Funeral	11. Marital Status  1 Never Married 2 X Married	12. Was Dece Armed For			s Decedent c es, specify C				cify Yes or No tican, etc.)	- 14. Race White		can Indian, Black,	
ter death		1 Yes 2 No 3 Widowed 4 Divorced of Yes, Give Year 1 Yes 2 No specify:									Specify:	Asi	an	
ours af atural camin	ē P	15. Decedent's Education (Specify on	or Dates:	completed)	16a. Deceden						16b. Kind of Bu	siness/l	ndustry	
16 n 72 h	Set 1	Elementary/Secondary (0-12)	College (1-			ost of working life. DO NOT use retired)					0		Caiana	
5-0036 led within 72 hours a tygiene. other than "natura the Medical Examination.	Completed	17. Father's Name (First, Middle, Last)	5+		Soi	tware				First, Middle, I	Maiden Surname		Science	
프 프 프 중 교	Be	Ram Chand Sharma						Srima	ati	Durgi :	Devi			
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	욘	19a. Informant's Name/Relationship (Ty			2.0						nber, City or Tow			
	ŀ	Alka Mitter / Dau  20a. Method of Disposition	ghter	[20b	2300 Place of Dispos					Date	Spring,		Tand 20904	
Baltimore, permit. Pages I an Department of Hea Important. If itel imjury or other tr		1 Burial 2 X Cremation 3	Removal from	m State Mor	crematory or oth	ner place) V				mber 28	Pothos		Manuland	
Itim ii. Pa urtmen ortant ry or o	1	4 Donation 5 Other Specify: 21 Sign Mary of Junes (Seprice/License)		Cre	ematori	um, In	C . dress o	of Facility		011		<u> </u>	Maryland evy Chase, Inc.	
Dept.		EXIK ()		M016	19 175	57 Wis	con	sin A	Aven	ue. Be	thesda.	Mar	yland 20814	
Physician		23a. Part I. Enter the disease, or complifailure. List only one cause on ea	ch line.		. Do not enter ti	ne mode of d	ying, sı	uch as car	diac or i	respiratory arr	est, shock, or he	art	Approximate Interval Between Onset and	
Examiner			letastat Due to (or as a c			rine T	umo	r of	Pan	creas			Death	
		Sequentially list conditions, b.	oue to (or as a t	sonsequence o	···).									
	<u>je</u>	if any, leading to immediate	Oue to (or as a	consequence o	f):								1	
=	Xam	(Disease or injury that initiated C	Due to (or as a	consequence o	f):		_							
O, e be executed sician and burial - transit	dical Examiner	d.  X UNPENDED	AMENDED 2	3a.pt.]	[1,27,p	er me,	g92:	3 1-1	2-1	2 sm				
50, te be enysicia	wr	IF FEMALE:		utcome of preg							23d. Date of	deliven	,	
ox 6876C sath certificate attending phys	an/	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th	2 Fe	tal death	3	Ectopic p	oregnan	су	Month	С	Day Year	
Box (e death or the attenued for us	Physician/M	1 Yes 2 No 9 Unknown	9 Unknow	int at time of de wn	5 Ot	her (Specify)								
that the d the detached		Part II. Other significant conditions	_		_		use giv	en in Part	I.				the cause of death?	
of Vital Records, P.O.  by Physician: The law requires that th  Wher this certificate has been signed by meral director, page 2 should be detach	ed by	Atherosclerotic	Cardio	vascula	ar Dise	ase							pably 4 Unknown	
sords, aw requir has been s	Completed	-								24a. Was autop	osy		topsy findings available completion of cause of	
Rec The la	8									1 Yes		<b>✓</b> Ye	es 2 No	
Vital Rec ysician: The his certificate director, page	8	25. Was case referred to medical examiner?	ospital: 1	patient 2	ER/Outpatient		_	of Death (Cother			Residence 6	✓ Other	r; Scene	
Ing Phys	입	1 ✓ Yes 2 No 27. Manner of Death	28a. Date o		28b. Time of I			at Work?			how injury occur			
ion tendin eath. tor: A	텵	1 X Natural 5 Pending 2 Accident Investigation		Day, reary		1	Ye	es 2 N	No					
Division tal or Attendi rs after death. al Director: A led in by the ft	Certification:	3 Suicide 6 Could not determined	28e. Place	of Injury - At h	ome, farm, stre	et, factory, of	fice bui	ilding, etc.	2	28f, Location ( or Town, S		er or Ru	ral Route Number, City	
Division  Bospital or Atter Hours after dear Funeral Director tely filled in by th		29a. Certifier	(Opcomy)	of my knowled	las doeth ossu	rad at the tim	an date	and plac	e and c	fue to the caus	se/s) and manner	r as stat	ed .	
hin the	edical	one) 2 ✓ Medical Examiner		f examination a										
To with	₩.	29b. Signature and title of certifier	and manufer St	4.0 W.				number	OCME		29d. Date sign			
		Theodor W	King	JR.	m. )	C	D.C.M	1.E.			December	24, 20	J11	
)		30. Name and address of person who of Theodore M. King, Jr., MD	•			900 W. B	altimo	ore Stre	et Ba	iltimore, M	D 21223			
Sta	ate	31. Date filed (Month, Day, Year)		gistrar's Signati	ure	_			, =	.,				
Regist		DEC 2 7 2011	Burne	. 1	Marker									

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2055 Decem Medical ocation of Death 4a. Facility Name (if not institution. County of Death **Examiner** COLUMDIS Howard al If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Fo 5. Social Security Number 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Min Director 212-28-5385 Usuzil Resinence of Daceder 1 □ M 2 🔀 F 12/11/28 Maryland 83 show 10d. Inside City Limits 10a. State aţ 10b. County 10c. City, Town or Location Funeral Director must be notified 28a-f 1 Yes 2 X No MD Harford Jarrettsville ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 2333 Cox Road 21084 items ; within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. 5 ģ 1 Never Married 2 Married 2 **X** No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify "natural", Completed 3 X Widowed 4 ☐ Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be Earl Michael Bernadette Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 2333 Cox Road Jarrettsville, Maryland 21084 Jack Mory / Son other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or Department of Important: If any injury or Loudon Park Cemetery 12/27/11 Baltimore, Maryland 4 □ Donation 5 🗷 Other (Specif 🖸 ntombment 21. Signature of Funeral Service Life see 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, maryland 21229 23a. Part 1. Enter the disease, or a shock, or heart failure. List part nplications that caused the death. Do not ascula Dickor Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequ burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of the attending physician hed for use as the buria Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months 1 ☐ Yes 2 ☑ No Pregnant at time of death been signed by the sahould be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of geath? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed completely filled in by the funeral director, page 2 this certificate has 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 7 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar 201-10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

D30641

December 22 20/1

Back Never Mac Road Ball

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year : 44P M Physician/ 3 elen Hs. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rathmore R nesis 9. Birthplace (State or Foreign 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) Funeral Min. Months Hours November 29 Marv Tand 1 🗆 M 2 😡 F 74 1937 213-34-9107 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a, State Director 1 Tes 2 XXNo Baltimore Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral IISA 221 Antietam Road 21221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: Specify: If Yes, Give Year or Dates Completed 3 KXWidowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications Telephone Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Florence Schwartz Harry L. Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen M. Dunstan/Daughter 2303 Knox Avenue Reisterstown Maryland 21136 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Woodlawn Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/11 baltimore Maryland 21. Signature on Funeral Service Licenses 2. Name and Address of Facility Conard J. Ruck, Inc. 305 Harford Road Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a c sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a cur sequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) this certificate has been signed by the attending physician al director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 Ø No Month Pregnant at time of death 9 Unknown g 🔲 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be examiner? Hospital: Other 1 🗌 Yes 2 🛮 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 🖊 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) ည 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8720 EM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 27 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  AMEND ITEM# 206, perFH, G923, 1/3/2012, WS State of Maryland / Department of Health and Mental Hygiene										
			For State Registrar	State of Maryland		te of Death	Reg.	2011	41353	
4	Physicia Medie		1. Decedent's Name (First, Middle, Last)		YA++he	ws Se-	2. Date of Death Month	Day Year	3. Time of Death 21 35 M	
mark.	Examir	er	4a. Facility Name (if not institution, give s GUCHRIST	Hospice		y, Town, or Location of Death	ON	4c. County of Death	timore	
	Funeral Director		5. Social Security Number  213 - 48 - 4603  Usual Residence of Decedent	7. Age (In yrs. Ia)	st birthday) If Und Months  Yrs.	er 1 Year If Under 24 Hrs.  Days Hours Min.	8. Date of Birth (Month, Day, Yea)	r) Count	lace (State or Foreign ry)  Mary has	
d 21215-0036	the Maryland or 28a-f show e notified at	ctor							0d. Inside City Limits	
		Director	10e. Street and Number 10f. Zip Code			10g.	Citizen of What Coun			
	nth with ms 23a must t	To Be Completed by Funeral	1408 Ang/ese	12. Was Decedent Ever in U.S.	Ap+ T-1	21224	again, Yan ar Na	WSA	•	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show item ZT is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1. Yes 2 No If Yes, Give Year or Dates.	If Yes, sp	edent of Hispanic Origin <b>?</b> (S _l ecify Cuban, Mexican, Puert 2 X No S <i>pecify:</i>	o Rican, etc.)	14. Race - America Black, White, e Specify:		
			15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of w life. DO NOT u	ork done during most of wor	king	. Kind of Business/Inc		
	ed within Hygiene. other than		17. Father's Name (First, Middle, Last)	12		A5Sº 10 LCR	me (First, Middle, Maid	en Surname)	TOTERS.	
Maryland	ild be fil Mental narked atic ev		Honory M. Matthews			JoK				
Mar	e = = =		19a. Intermant's Name/Relationship (Type, Print)  - 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  JACQUELINE MATTHEW. WIFE 1468 ANGLESEA ST. Apt T-1 Balto 40 21224							
ore,			20a. Method of Disposition  1 M Burial 2 Cremation 3 F	20b. Pla	ace of Disposition (Na emetery, crematory or	ame of Vary (Control other place)	Date 20c	. Location - City or To	wn, State	
Baltimore,	permit. Page Department o Important: If any injury or once.		4 Donation 5 Other (Specify)  21. Signatury Fungs Service Licensee  22. Name and Address of Facility Joseph Zanning Jack							
m	Depar Impo any ir		1643~	/	263	5-Conk1,	in 5+ 13	Alto Md	21224	
	nysician/		23a. Part 1. Enjer the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock on he it is not contained. List only one cause on each line. Immediate Cau							
	Medical Examiner		disease or continon resulting in death)  a. Due to (ork s a consequence of):							
	_ +	iner	Sequentially list conditions, if any, leading to in modilate cause. Enter Underlying  b. Use to (or de a consequence of):						pers.	
	eath certificate be executed sattending physician and d for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):							
		dical	d							
Box 68760		Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	nonths?  1  Live Birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify)				23d. Date of delivery Month Day Year		
P.O. B	at the do		9 ☐ Unknown 9 ☐ Unknown					e. Did tobacco use contribute to the cause of death?		
JS, Р	luires th en signe uld be c	ed by						1 Yes 2 □ No 3 □ Probably 4 □ Unknown		
cor	The law req	Completed					24a. Was an autopsy	prior to cor	osy findings available inpletion of cause of	
a B	hysician: his certific	To Be	25. Was case referred to medical			26. Place of Death (Che		No 1 Yes	2 🗆 No	
f Vit			examiner? 1  Yes 2 No He  27. Manner of Death	OA Other: 4 \( \to \) Nursing Home 5 \( \to \) Residence 6 \( \to \) Other (Specify) \( \to \) \						
o uo			27. Manner of Death   28a. Date of injury   28b. Time of injury   2   Accident   1   1   1   2   28a. Date of injury   28b. Time o			work?  M 1 ☐ Yes 2 ☐ No		ion (Street and Number or Rural Route Number,		
Division of Vital Records,										
			29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	To th Withir To th COMP	ı —	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)					Day, Year)		
ļ	/ x		30. Name and address of person who cou	U 58505	honles of towson MD					
Ų	V		31. Date filed (Month Day, Year)	Wes WO (	5201 N.	Charles &	I Tanso	m mo		
	Stat Registra		DEC 2 7 201		back	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 24, 2011 George Jerome Norvell 7:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore Middle River 1308 Goose Neck Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**√**M 2 □ F Days Hours 06/09/1922 Director Marvland 89 216-16-0719 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d, Inside City Limits must be notified at Director 1 Ves 2 No Maryland Baltimore Middle River 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a U.S.A. 1308 Goose Neck Road 21220 Department of Health and Mental Hygiene. Important: If item 27 is marked other the any niury or other traumer. Important: If item 27 is marked other the any niury or other traumer. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates. 1 Yes 2 No Specify LIMMI Completed 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Jerome Norvell Mary Foltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1308 Goose Neck Road, Baltimore, Maryland 21220 Agnes Ward Norvell (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. 12/28/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of achieves in Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immedic cause. Enter Underlying Cause (Disease or imjury Examir the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Chalestrot 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? this certificate 2 🗌 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 卢 1 ☐ Yes 2 🕱 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 Yes 2 No 5 Pending Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4920 Campbell Blud, Balti-RANA 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41355 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LILLIAN NORWOOD DECEMBER 23 2011 07:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GILCHRIST HOSPICE CARE TOWSON If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 10/12/1926 Days Hours Min 216-24-8196 **Director** 1 - M 2XXF 85 iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21209 USA 2211 WEST ROGERS AVENUE and Mental Hygiene. is marked other than "natural", or items. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. WHITE If Yes, Give Specify: 3 Divorced 4 Divorced Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWNER RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EUZENT MINNIE GOLDMAN MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tractonce. MILTON NORWOOD/HUSBAND 2211 WEST ROGERS AVENUE, BALTIMORE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) REISTERSTOWN, MD NSON & BROS., INC. 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM. 12/26/2011 22. Name and Address of Facility SUL LEVINSON & BROS., 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 2014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ⊩h sician/ monthy Smell disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 2 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Yes ed by the a detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has certificate has lirector, page 2 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Tyes ျ 6 Other (Specify) VOSP (Q 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No neral Director A Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after da To the Funeral Directo completely filled in by it 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 8303 December 23 2011 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Charles ST Tonson MO Agran HARLES ND 6701 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month (1:48 AM Physician/ PAUL E. OLIPHANT 2011 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE CITY N/A 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours **Director** 219-42-1760 1 XM 2 □ F 7/20/1946 65 MARYLAND Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD BALTIMORE GLEN ARM 10f. Zip Code 10g, Citizen of What Country? items 23a or ner must be n 10e. Street and Number Funeral 12836 KANES ROAD 21057 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian the Medical Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. ö 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: WHITE "natural", 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) HOME IMPROVEMENT OWN BUSINESS 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ဂ္ JAMES OLIPHANT HELEN PINTI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE STENZEL-OLIPHANT/WIFE 12836 KANES ROAD GLEN ARM, MD Important: If item 27 any injury or other tra 21057 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/28/2011 | BALTIMORE, MD PARKWOOD CEMETERY 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signat e of Funeral Service TOWSON. 8521 LOCH RAVEN BLVD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ears Sequentially list conditions, Examine flaty, leading to immedicause. Enter Underlying -transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the as ding IF FEMALE 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 40 1 Inpatient 2 မ ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending Investigation 2 Accident
3 Suicide
4 Homicide Accident Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🕯 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Samara, Waish M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33 rd 200 East amava 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 41357 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Timosly 0904 2011 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford 5. Social Security Number 6. Sex 1 M 2 D F If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Baltimore, Maryland 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Hours Days 72 June 1 1 2 1939 Vrs **Director** 213-36-0192 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Harford Forest Hill 1 Tes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 110 Gwen 21050 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Divorced 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Bread Truck Driver Elementary/Seconday (0-12) College (1-4 or 5+) Food Sales 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles O'Hara Evelyn Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy O'Hara (Spouse) 110 Gwen Drive, Apt. 3B, Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State December 27, Parkville, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensed effrey R. Testerman 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air 3 Newport Dr. Forest Hill, Maryland 21050 (M01543) 23a. Part 1 Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Tetal 30 in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an Were autopsy findings available prior to completion of cause of autonsy death? 1 Yes 2 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No División Accident Suicide Investigation
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 7027 29b. Signature and title of certific 1 23a) (Type, Print)
500 Upper Chesapeake Dr. address of person who completed cause of death (Item 23a) (Type, Print)
Teven Foundarn, MD 500 Upp State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ecernbe Medical 4c. County of Death Facility Name (if not institution, give street and number) City, Town, or Location of **Examiner** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. Feb. 17 Country) Year 1921 90 TX**Director** Usual Residence of Decedent should be filed within 72 nows arre. It and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show arked other than "natural", or items 25a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location Director 1 ☐ Yes 2x No MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 710 Obrecht Road 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White Completed 3 X Widowed 4 Divorced Year or Dates. injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Technician Laboratory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edna Ridigs V. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other tra 1859 Lona Linda St., Sarasota, FL 34239 Mrs. Terry O. Brackett (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
All County Cremation 1 Durial 2 Cremation 3 Removal from State 12/24/2011 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 100769 Sykesville. MD 21784 23a. Part 1. Enter the disease, or complications wat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially liet on alliane if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last and trar Due to (or as a consequence of): nding physician use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an pate has page 2 s performe this certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 1 Tyes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After iniury Natural 5 Pending work? 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the f 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 1 This

Date filed (Month, Day, Year)

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amend #9,1 Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 0216 P & C 6 4 OSBORNE A Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner SILVER SPRING CROSS HOSPITAI MONTGOMER If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Washington DO 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🖫 F 70 UWY Director 77-44-4390 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location Director 1 Yes 2 No SPRING MONTGOMERY SILUER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20904 #242 RANDOLPH be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates. · Widowed 4 Kivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Research Analyst and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Liberty of Congress College (1-4 or 5+) YWW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidea Sumame)
Lena Strobert 0 Connell ည NNK Page 1 and 2 should 639 ailing Address (Street and Number of Bural Route Number City 2000 2 tate, Zip Code) 19a Informant's Name/Relationship (Type, Print)
Richard Usborne—son Department of Health a Important: If item 27 is any injury or other trains cross Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ature of Fune 1 Sen Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Disease Oronar Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that in literated expense. Examine Due to (or as a consequence of): nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months: Day 5 Other (specify) Pregnant at time of death signed by the a Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 1 Yes 2 🖼 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes 2 No Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MU 00064624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Summer Walk Dr. Greithersbury SHARMA 243 31. Date filed (Month, Day, Year) Registrar's Signatu State DEC 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 16 Month 12 Physician/ 2047 PM GLORIA ODEN Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Yes 9. Birthplace (State or Foreign 6. Sex **Funeral** 1923° New York Director 127-16-5845 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show , the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 WNo Maryland Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 United States 707 Maiden Choice Ln. Apt.#8119 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black If Yes, Give 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 7 h and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Author, Poet, Professor Education traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ం Ethel Kincaid permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Redmend S. Oden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hedley A. Clark/PR-Lawyer 40th Street Suite 204, Baltimore, MD. 21211 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Dec. 23, 2011 Glen Burnie, Maryland Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring RD., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between THORACIC ADRTIC ANEURYSM Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CARDIOVASCULAR DISEASE ATHEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Other (specify) Pregnant at time of death signed by the a g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 000 Division of Vital Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy After this certificate has perform death? Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certifica 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at iniurv work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12-16-2011

State Registrar

DHMH 17 Rev 7/2009

30. Name and

31. Date filed (Month, Day,

SOUTH GREENE ST., BALTIMORE, MD 21201

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TERHUNE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:50PM 2011 Patrick Joseph 0'Hare Decembe 30 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner Himore osedal Tal 8. Date of Birth
(Month, Day, Year)
March 28,1961 ocial Security Number If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under **Funeral** Months Hours Min. Country) 1 M 2 D F Yrs. Director 215-88-1525 50 Maryland March Usual Residence of Decedent or 28a-f shov 10b. County 10a, State 10d. Inside City Limits with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 1 ☐ Yes 2 X No MD Baltimore Essex 靣 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Mistletoe Court 21221 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐XNo Specify: "natural", Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Union President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H Is marked of မ Mary M. Reynolds permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 Is marke any injury or other traumatic once. Michael B. O'Hare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21221 4 Mistletoe Court Essex, Maryland Mrs. Pamela Jean O'Hare(Wife) Itimore, 20a. Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sacred Ht. of Jesus Cem.12/27/2911 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
2022 Mice Ave. Dundalk, Maryland 21222 21. Signature of Funeral Service License Baj Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death signed by the a d be detached f 2 🗌 No Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown has been signed by 2 should by Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate ha irector, page 2 performe death? Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Director: Investigation Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 KirmanJ

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OXENDINE Dav Month LINDA RENEE 23:14 DECEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL CITY BALTIMORE 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 Months Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No + (more 10f. Zin Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral W-SA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates. Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) Drendine I and 2 should be and of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the strength of the s ည 19a. Informant' ame/Relationship (Type, Print) Mothen BONNIC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-26-2011 21. Signatu Funeral Service Licensee 23a. Part 1. Enter the ease shock, or hear ailure. ease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Inal Physician/ GASTRO INTESTINAL disease or condition resulting in death BLEEDING Medical Due to (or as a consequence of): Examiner IRRHOSIS Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death by the Unknown P.O. Part I<mark>I. Other significant conditions c</mark>ontributing to death but not resulting in the underlying cause given in Part I signed to 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l , page 2 s autopsy Yes 2 No this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 

Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 22, 2011 RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOLFE STREET BALTIMORE MD 21287 L BOUEIZ 600 N

State Registrar

		_ For	<b>Type or Pri</b> State of M		d / Depa	rtment of I	Health and M	-			4136	
		State Registrar			Cer	tificate of l	Death	F	Reg. No.			
Dhuaisia	/	1. Decedent's Name (First, Middle, Last	)					2. Date of Dea Month	th Day	Year	3. Time of Death	
Physicia Medio		Gregory			P	ickett	Sr.	Decem		2011	19:27 M	
Examin		4a. Facility Name (if not institution, give s		Him	( e)	U CT	r Location of Death	244	4c. Count	y of Death		
Funeral		5. Social Security Number 6. Se		je (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Vearl	9. Birthp Count	lace (State or Foreign	
Director		Usual Residence of Decedent	□M2□F (	64	Yrs.		Thouse Mills	01 03			MD	
Aaryland 8a-f sho tified at	Funeral Director	10a. State 10b. County NA		10c. City,	Balt	imore				11	10d. Inside City Limits 1 □X/es 2 □ No	
or 2	₫	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?	
with with ust b	era	5114 Norwood Av	e			21	207		Ü.	S.A.		
Ind 21215-0036  filed within 72 hours after death with the Maryland tal Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status  1 ☐ Never Married 2 ※ Married  3 ☐ Widowed 4 ☐ Divorced	er Married 2 Married Armed Forces?			Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra	ce - America		
hour hour natu	Sete	15. Decedent's Ec (Specify only highest gra	ucation	- 1	16a. Deced	ent's Usual Occup	pation		16b. Kind of I			
d Z1Z13-UU30 ed within 72 hours after Hygiene. ther than "natural", o ent, the Medical Exam.	Completed by	Elementary/Secondary (0-12) 12th grade	College (1-4 or 2 2 yrs	5+)	life. DC	nna of work done () NOT use retired) ergeant	during most of worki	ing		Maryland Correcti		
filed y	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name	e (First, Middle, I	Maiden Surnan	ne)		
arylan should be fi and Mental is marked sumatic ev	욘	John Pickett					Georget	tta Cro	slin			
re, Maryland 1 and 2 should be filed f Health and Mental Hy item 27 is marked oth other traumatic event		19a. Informant's Name/Relationship (Ty	oe, Print)		19b. Mailin	g Address (Street	and Number or Rura			State, Zip C	ode)	
		Barbara Pickett	-Wife		5114	Norwoo	d Ave, H	Baltimo	ore, M	d 21:	207	
Page nent o ant: If iry or		20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify		cer	metery, crem	sition (Name of eatory or other place Forest	ce)	Date 8/2011	20c. Location	•	wn, State	
Daltilli permit. Page Department Important: any injury o		21. Signature of Funeral Service License	e /// .		Ma	Name and Addre						
2 8 2 E 8 8		Ressin .	Must	2	4.	300 Wab	ash Ave	Balti	imore,	Md .	21215	
Physician/ Medical Examiner	77	23a. Part 1. Enter the disease, or comb shock, or half failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line a	e.	Inters		ng, such as cardiac c		est,		Approximate Interval Between Onset and Death	
ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any leading to it mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as  d.									
the Hospital or Attending Physician: The law requires that the death certificate be, thin 24 hours after death.  The Funeral Britectors After this certificate has been signed by the attending physician mpletely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5 Other (specify)							23d. Date of delivery  Month Day Year		
es that the signed by d be detail	Completed by Pr	Part II. Other significant conditions co	ntributing to death b		ting in the u	nderlying cause gi	ven in Part I.	23e. Did to	/	acco use contribute to the cause of death?		
requi been shoult	lete	Day to T	)					24a. Was a			sy findings available	
sician: The law r certificate has b lirector, page 2 s	m	Novels> 11 bo						autop perfor	sv	prior to cor death?	npletion of cause of	
The icate r, pag		Albertenzion						1 \( \text{Yes}	2 No	1 🗌 Yes	2 No	
cian certifi ecto	Be	25. Was case referred to medical examiner?	lospital:		_		lace of Death (Check	k only one)				
hysi this c	은	T LI Yes 2 De No	1 inpati		R/Outpatien		4 L Nursing Ho	ome 5 Resid				
eath.	Certificate:	27. Manner of Death  1 Matural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of inju (Month, Da	ury 2 y, Year) 2	8b. Time of injury	28c. Injur work M 1		28d. Describe how injury occurred				
To the Hospital or Attending Physician: Within 24 hours after death.  To the Funeral Director After this certifica completely filled in by the funeral director,		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	ury - At hom c. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Si City or Town	off. Location (Street and Number or Rural Route Number, City or Town, State)			
ne Hospi n 24 hou ne Funer oletely fill	Medical	29a. Certifier (Check (Check only one) 1 Certifying Phys 2 Medical Examir only one) 3 Certifying Nursi	er: On the basis of e	examination a	and/or investi	gation, in my opini	on, death occurred at	t the time, date ar	nd place, and d	ue to the cau	ise(s) and manner stat	
To th within To th		29b. Signature and title of certifier		,	5.7	29c. Licens			29d. Date sign			
Ot 1		30. Name and address of person who do	Jue mo	looth (ltown)	12a) (Tia D	100	1129	+	) eccm)	oer !	9,2011	
T,		30. Name and address of person who co	e mo.	Sin	ال ين	lotiges	of Bi	Milthe	270			
Stat Registra		ner 2 7 2	32. Fegistra	ar's Signatu	1. 4	all						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:05 PM Daniel Ellsworth Piper 12 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEALTHCARE HAGER STOWN **SMU** WASHINGTON If Under 1 Year If Under 24 Hrs. Social Security Number 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Mar 30, 1**X** M 2 □ F Maryland 1935 Director 220-28-8316 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Williamsport Maryland Washington 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? Funeral 21795 United States 11308 Sword Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by XYes Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give 3 Divorced 4 Divorced Caucasian Year or Dates.1958-1960 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Anna Buryl Fleet Samuel Webster Piper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3679 Nile Rd. Davidsonville, MD 21035 Jean Elizabeth Piper / Niece Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place, Final Journey Crematory 12/24/2011 Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Coing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, M MD 21029 23a. Part 1. Enterpre disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) PAILLUKE TO THRIVE Medical Due to (or as a consequence of) Examiner AUZHEIMER DEMENTIA Sequentially list conditions rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 34 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a d be detached fi 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed? Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work' 2 🔲 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 12-21-2011 K118578 MARCH PIKE MICHELLE EYLER 14014 HAGERSTOWN, MD 21742 State DEC 27 2011 Registrar

11-09407 Jeff Parker, Jr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2011 41365

	1- For State Constraint of Department of Treatment of Mentan 1  Certificate of Death  Registrar		g. No.		
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  Jeff Parker Jr	2. Date of Death Month December		3. Time of Death 1140 hrs	
	4a. Facility Name (if not institution, give street and number) 4405 Marble Hall Apt 217  4b. City, Town, or Location of Deat Baltimore	h	4c. County of Death		
Funeral Director	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	_	h(MM/DD/YYYY) 9. Bir 5 / 1959 Foreig Co		
Varyland 28a-f show any d at once.	Usual Residence of Decedent  10a. State			10d. Inside City Limits 1 X Yes 2 No	
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 10f. Zip Code 4405 Marble Hall Apt 217 21218	10	g. Citizen of What Cour	ntry?	
er death with , or items 23 r must be no	11. Marital Status 1 Never Married 2 Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 1 Yes 2 No specify:		White, etc.	can Indian, Black,	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shu other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business/Industry		
215-0036 be filed within 72 hour mal Hygiene. rked other than "natuent, the Medical Exament, the Medical Examene.		e (First, Middle, M	Education Surname)	)II	
and 2 should be filed within tealth and Mental Hygiene. ten 27 is marked other the traumatic event, the Med To Be Com	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or		per, City or Town, State		
re, MD 1 and 2 sho Health and fitem 27 is r traumati	Patricia Parker Mother 1012 Argonne Driv  20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	e Balti	more MD 2		
Baltimore, permit. Pages   an Department of Hea Important: If iten injury or other tr	1 Burial 2 Acremation 3 Removal from State Atlantic Crem 12  4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Si	/23/11			
m a a m m m m m m m m m m m m m m m m m	Thomas Allen PA 7 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	090 Rid	lge Rd Hai		
/Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease			Between Onset and Death	
5	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):				
ted Insit	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C Due to (or as a consequence of):				
60, ate be executed obysician and ne burial - transit	d. UNPENDED AMENDED				
	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregn 4 Pregnant at time of 5 Other (Specify)	ancy	23d. Date of delivery  Month	ay Year	
P by th	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	he cause of death?	
- 8 go e	Chronic Alcoholism	1 Yes	2 No 3 Prob	ably 4  Unknown	
Reco		autops perforr 1 <b>V</b> Yes 2	y prior to c ned? death?	ompletion of cause of	
Vital hysician: this certiful director,	25. Was case referred to medical examiner?  1 ✓ Yes 2 No    No   No   No   No   No   No   No		Residence 6 🗸 Other	Scene	
ion of ' tending Ph sath or: After t the funeral	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 V Natural 5 Pending	28d. Describe h	ow injury occurred		
Division pital or Attendiours after death cral Director: A	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St or Town, Sta	reet and Number or Ru ate)	al Route Number, City	
Division o  To the Hospital or Attending within 24 hours after death To the Funeral Director: Afte completely filled in by the fune Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
<b>A</b>	29b. Signature and title of certifier  O.C.M.E.		29d. Date signed <i>(Mor</i> December 15, 20		
	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 2	1223			
State Registrar	31. Date filed (Moeth, Day Year)  32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death n Month Physician/ Year Patricia E.Phillips 12230 PM Reember 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Balto. Randallstown Season's Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 30,1934 Months Hours 215-30-5730 **Director** 1 🗆 M 2 🟋 F 77 Yrs Maryland Usual Residence of Deceden 28a-f shov be filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Middle River Balto. Md 1 Yes 2x No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 USA 538 Holly Hunt Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc ò Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify "natural" 3 ☐ Widowed 4 🙀 Divorced 5. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of မ Charles Lentz permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic once. agnes Shanahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 538 Holly Hunt Road Middle River, Md. 21220 Son George M. Phillips 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-29-2011 Dundalk, Md. Sacred Heart of Jesus Charles S. Zeiler and Son, Inc. Signature uneral Service Licensee 22. Name and Address of Facility ( d Balto.Md. 21224 6224 Eastern Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on/each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ 19 mony 5 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events the attending physician and Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown should peen s Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy perform Yes Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	For State	State of Maryland	/ Depa		lealth and I	Mental Hygi	_	11 4136				
ysician/ Medical	1. Decedent's Name (First, Middle, Le FREDERIC  A Facility Name (First institution dis-	ck PAF		Sr		2. Date of Death	2 ^{Day} 2	Year 3. Time of Dear M				
aminer	4a. Facility Name (if not institution, giv 3416 Chapman Ro	ad	ì	Rand	Location of Death		4c. County o	altimore				
neral ector	5. Social Security Number  219-22-5716  Usual Residence of Decedent	Sex 7. Age (In yrs. lasi	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1)  March 9,		Birthplace (State or Foreign Country)     NY				
notified at Director	10a. State 10b. County  MD Baltin	10c. City,	Town or Lo	cation	<u> </u>	platell 33	1727	10d. Inside City Limits 1 ☐ Yes 2 X No				
st be no	10e. Street and Number  3416 Chapman Ro		Range	10f. Zip Code	1133	10	g. Citizen of W	ŕ				
any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give	ŀ	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 🏋 No	ispanic Origin? (Sp n, Mexican, Puerto	14. Race	14. Race - American Indian, Black, White, etc.					
the Medical Ext	15. Decedent's (Specify only highest g		(Give I	lent's Usual Occupa kind of work done of D NOT use retired)			White Kind of Business/Industry  Local 11					
To Be C	6 17. Father's Name (First, Middle, Last)  David Paff,			Ins	18. Mother's Nan	ne (First, Middle, Ma Stella						
r trauma	19a. Informant's Name/Relationship (					ral Route Number, (		ate, Zip Code)				
y or othe	20a. Method of Disposition  1 X Burial 2 Cremation 3	20b. Placen Removal from State	ce of Dispo netery, cren	sition (Name of natory or other plac	e)	Date 2	Oc. Location -	City or Town, State				
any injun	4 Docation S Other (Special Signature of Funeral Service Licer	1100	22	<u>e Cemeter</u> . Name and Addres Line Fune	ss of Facility		Reist	erstown Road n, MD 21136				
cian/	23a. Pad 1. Enter the disease, or con shock, or heart allure. List only Immediate Cause (Float disease or condition	pplications that caused the death. one cause on each line.						Approximate Interval Between Onset and Death				
dical niner	resulting in death)  Sequentially list conditions,											
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer  Due to (or as a consequer										
the burna	C	■ d										
Medical Certificate: To Be Completed by Physician/Medical Exami	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome of pregnanc  1  Live Birth 2 Fetal c 4 Pregnant at time of dea 9 Unknown	leath 3	Ectopic pregnanc		23d. Date of delivery Month Da						
ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute 1  Yes 2 No 3											
Completed		/ere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2 ☐ No										
To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatien	Othe	ace of Death <i>(Cheder:</i> 4  Nursing H	ome 5X Resider	ice 6 🗌 Othe	r (Specify)				
l in by the funeral  Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	3b. Time of injury	28c. Injury work M 1	/ at	28d. Describe how						
I Certi	3 Suicide 6 Could not 4 Homicide determined		eet and Numbe State)	t and Number or Rural Route Number, tate)								
Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	vsician: To the best of my knowled hiner: On the basis of examination a rse Practitioner: To the best of my	nd/or invest	igation, in my opinio death occurred at the	n, death occurred a he time, date and p	at the time, date and lace, and due to the	place, and due cause(s) and m	to the cause(s) and manner state anner as stated.				
O I	29b. Signature and title of certifier	Dhim	9	29c. License	e number		/\	(Month, Day, Year)				
	(haroun oc	completed cause of death (Item 2:	Jeiz	phlas	Blud	Alen Be	RUIL	021061				
State gistrar	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	1 4	all								

DHMH 17 Rev 06-2011

## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	For State	lease 1	• •		Black II nd / Depa	artme	nt of H	lealth a		•			gible.	
an/	Registrar  1. Decedent's Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (First, Name (				Cei	tifica	te of E	Death_		2. Date of I	Reg. N	10. 2	0   2 ^{Ye} 3"/	3. Time of Death
er	4a. Facility Name (if not instite  Western Man	ution, give st			em		y, Town, or umber		of Death	1701	4c. County of Alle			h У
	5. Social Security Number 220-52-7410	7. Age (In yrs.	62 Yrs. Hast birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min									9. Birthplace (State or Foreign Country)		
ctor	Usual Residence of Deceden 10a. State 10b. Co	unty		cation							10d. Inside City Limi			
any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	MD A.  10e. Street and Number  13800 McMu	llegan		C	resapto	10f. Zip Code 21502						10g. Citizen of What Country?		
ed by Funeral	11. Marital Status unk  1 Never Married 2 3	Married 1	12. Was Dece		ver in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-								ack, White	rican Indian, e, etc. Lte
<b>Completed</b>	15. Der (Specify only of Elementary/Seconday (0- unk		cation	4 or 5+)	(Give	ecedent's Usual Occupation unk ive kind of work done during most of working e. DO NOT use retired)						16b. Kind of Business Industry unk		
To Be	17. Father's Name (First, Mid	die, Last)      U	ınk					18. Mothe	er's Nam	e (First, Midd	le, Maide	n Surnan	ne) unl	ζ
	19a. Informant's Name/Relationship (Type, Print) Western Correctional Institue  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St 13800 McMullen Hwy; Cumberland, MD  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location -													
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation → \$\mathbb{X}\$ Other (Specify) \( \bar{\textbf{I}} \) \( \bar{\textbf{n}} \) \( \bar{\textbf{state}} \)													Town, State
	21. Signature of Euperal Sen Ronal	rice Licers	de, I	irecto	or 22					ate An St; B				21201
n/ al er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Les pivalory Acido & & But to (or as a consequence of):  Mo Las Haby Lung Cam Cerv												Approximate Interval Between Onset and Death	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	<b>1</b>	Due to (c	or as a consequence of a second of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence	ras a consequence of):  Stromal Cell termowr ras a consequence of):									
dical	Gastro intestinal Gleed													
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23	1 🔲 Live E	ant at time of	Fetal death 3 Ectopic pregnancy						23d. Date of de Month			livery Day Year
ğ	Part II. Other significant con	nditions con	tributing to de	ath but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute  1  Yes 2 No 3			
Completed										pe	as an topsy rformed?		prior to death?	topsy findings availab completion of cause of
Be	25. Was case referred to med examiner?  1  Yes 2 No	-	ospital:				Louis	or		k only one)				
Certificate: To	27. Manner of Death 1 Matural 5 P	ending vestigation	28a. Date o		28b. Time of injury		28c. Injury work	4 LINu ≀at			ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
	3 Suicide 6 C 4 Homicide de	eet, facto	ory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Medical	(Check 2 🔲 Medi	cal Examine	er: On the basi	s of examination	vledge, death on and/or inves ny knowledge,	tigation, i	n my opinio	n, death oc	curred a	t the time, dat	e and place	ce, and d	lue to the	cause(s) and manner st
	29b. Signature and title of ce		Chen	alla			9c. License	,	76		29d. Date signed (Month, Day, Year)			
	30. Name and address of per Manohar Kum	son who cor	mpleted cause	e of death (Iter	m 23a) (Type, F		Rđ St	e 30	4 A	delphi	, MD	207	83	
ate rar	31. Date filed (Month, Day, Ye		32. Re	egistrar's Signa	ature	1				-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ December 20°11 8:00 P M Debra Lou Parry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll New Windsor 207 Main St. 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours 220-82-5314 **Director** 1 □ M 2 🏻 F 51 Oct. 7, 1960 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director notified New Windsor 1 X Yes 2 No Maryland Carroll 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? must be Funeral 23aU.S.A. 21776 207 Main St. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4X Divorced Specify White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working I Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) maintenance cleaning services Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be Ruth McGraw James Krebs Sr. and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a New Windsor, MD 21776 Sue Stambaugh/ sister 2333 Marston Rd. Page 1 and 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 0 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or Sandymount Un.Meth.Cem. 12/22/11 Finksburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Lig 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that we sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 4 No Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Yes 2 - No ours after death.

eral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 HNO မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death Time of Certificate: 28h 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours

To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kevin Regusters		State of Maryland / Department of Health an  1- For State Certificate of Death  Registrar	d Mental Hyg		g. No. 201	1 4137			
Physician Medical Examine	n/ 1. Decedent's Name (First, Middle,Last)								
+		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or	Location of Death	December	4c. County of Death	0020 hrs			
<b>.</b>	4	Sinai Hospital Baltimore	- I Ki badas Odbies Tr	9 Data at Bird	N/	A Charles of Charles are			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Day		8. Date of Birt	h(MM/DD/YYYY) 9. Bir Foreig Co				
	ŀ	Usual Residence of Decedent		UF 103	1100				
ow any	-	10a. State 10b. County 10c. City, Town or Location Baltimore				10d. Inside City Limits 1 Yes 2 No			
aryland	Director	10e. Street and Number 10f. Zip Code		10	g. Citizen of What Cou				
ith the Maryland 23a or 28a-f show notified at once.	2	5314 Kenilworth Avenue 21	212		USA				
th with the terms 2.	runerai		spanic Origin? ( Speci n, Mexican, Puerto Ric		14. Race - Ameri White, etc.	ican Indian, Black,			
21215-0036  Uld be filed within 72 hours after death wi Mental Hygiene marked nither than "matural", ur items cevent, the Medical Examiner must be to Per Commission and the fireness of Per Commission and the fireness.		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No	specify:		specify: Bla	CK			
hours a	ed D	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupal during most of working life	ion (Give kind of work	k done	16b. Kind of Business/I				
hin 72 e.e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  CALDER  CALDER		,	Morgan S Universit	stale V			
5-00 lled with Hygien Inther	5	17. Father's Name (First, Middle, Lest)	18.Mother's Name (F	irst, Middle, M	laiden Surname)	<del>`</del>			
2121 tould be fill d Mental H is marked tic event,		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stree	Turand	al Poute Numb	HES har City or Town State	Zin Codo)			
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked uther than numaric event, the Medica	- [	Towanda Denean Sykas (Maker) 5314 Kenilin	vorth Ave	enue)	Baltimure	, MD 21212			
	- 1	20a. Method of Disposition  20b. Place of Disposition (Name of cer Disposition (Name of cer Crematory or other place)		ate	20c. Location - City or				
.트 유 홈 를 들니		4 Donation 5 Other Specify: King Park Memorial Signature of Funeral Sergice Licensee 22. Name and Address		2011	Windsor				
Balti permit. Departn Import injury	-	Vauch C. 2 8728 Lib	- Ity Road	Phan	dallstown	MD 21133			
Physician // // // // // // // // // // // // //	T	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, failure. List only one cause on each line.	such as cordiac or re	spiratory arre	st, shock, or heart	Approximate Interval Between Onset and			
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Sharp Force Injuries  Due to (or as a consequence of):				Death			
* 6 ₀₀₋₅₀₁₋₂ 14 *	_	Sequentially list conditions,							
Parisit is a second		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c.							
ansit and AC		events resulting in death) Last  Due to (or as a consequence of): d.							
O, A A Sician and burial - trans	3	UNPENDED AMENDED							
	2	IF FEMALE:  23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3	Ectopic pregnancy	,	23d. Date of delivery	y Day Year			
). Box 68760 the death certificate by the attending physched for use as the behave in a physician Me	2	past 12 months?  4 Pregnant at time of death  5 Other (Specify)			Month	ray real			
D. BC the der by the a		Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	iven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?			
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death.  **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Commonated by P.	5			1 Yes	2 No 3 Prob	ably 4 Unknown			
Records, The law requires ficate has been sig	2			24a. Was ar autops	y prior to c	topsy findings available ompletion of cause of			
tal Rec				perform Yes 2	ned? death? No 1 Ve	s 2 No			
Vital F hysician: ' this certific d director, I	5	evaminer?	of Death (Check only Other Nursing H		Residence 6 Other	:			
ding Phy. L. After tl funeral	17	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury (Mgnth, Day, Year)	0,1	d. Describe ho	ow injury occurred				
Sior Attend r death ector: by the		2 Accident Investigation 28e Place of Injury At home farm street factory office by	es 2 V No		reet and Number or Rui	ral Pauta Number City			
Division o supital or Attending hours after death, meral Director: Afty filled in by the func Certification:		3  Suicide 6  Could not be determined		or Town, Sta		al Route Number, City			
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, do note)  A Medical Examiner: On the basis of examination and/or investigation, in my opinion							
To t withi Ta t	Check only one 2 Wedlcal Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as some one one of the cause of								
		Caroe Hallain O.C.M	M.E.		December 22, 20				
6	17	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD _Assistant Medical Examiner 900 W. Baltimore Street,	Baltimore. MD 2	21223					
State	e 3	31. Date filed (Martin Pay Jean) 2011 32 Registrar's Signature Sauce							
Registra	Ц	Manage Jan Manage							

OCME

State of Maryland / Department of Health and Mental Hygiene 2 \(\infty\) Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bernard Joseph Reichert Month Medical ECEMBER 2011 8:45A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 218-32-7180 Months Days Hours 75 March 3,1936 Phoeria, Maryland Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkton Baltimore County Maryland 1 Yes 2 No 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? **United States** "natural", or items 23a or 21120 Funeral 1607 Armacost Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 H No Specify. If Yes, Give Year or Dates. **Percetime** White Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Machinist A.A.I. is marked other Be Baltimore, Maryland Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Anna Niemczycki** Mental ೭ Daniel Robert Reichert, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Poll+imore, Maryland 21214 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra Mr.Paul J. Reichert 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Harford County) Date Evans Fureral Chapeland Cremation Service, Inc. 1 Burial 2X Cremation 3 Removal from State Saturday 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Dec. 24, 201 21. Signature of Funeral Service Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licenses Licens Lic.#M00677 2325 York Road Timonium, Maryland 23a Garth. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Medical resulting in death) Examiner IMMIA Sequentially list conditions, cause. Enter Underlying Physician/Medical Exam Cause (Disease or iinjury cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 2 🗌 No 1 Yes 2 🔀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 12+1 ss of person who completed ca use of death (Item 23a) (Type, Print) Orth Chiles STESSO BAIN MOLEMB 21204 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Roland Robinson December 2011 8:15 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Columbia Howard Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 297-01-3869 **Director** 1 **X**M 2 □ F Yrs 91 Dec 21, 1920 Ohio with the Maryland at 10b County 10c. City, Town or Location Director r 28a-f si notified 1 Yes 2 X No Maryland Howard Laurel 10e. Street and Number ò 10a. Citizen of What Country? ms 23a or must be r Funeral 8214 Mary Lee Lane 20723 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married X Yes Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify 3 Widowed 4 Divorced Completed Year or Dates.1947-1955 White Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Agency 12 Spy National Securit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked မ Donald Robinson item 27 is marke other traumatic Edna Lower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Marie A. Jenkins / Daughter 8214 Mary Lee Ln. Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 12/26/2011 Woodbine, Maryland 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FROBABLE LUNG CANCER disease or condition MUNTHS Medical resulting in death) Examiner Sequentially list conditions if any cause Enter Underlying Examine Due to (or as a gone of length of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 the nding p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live Birth
4 Pregnant
9 Unknown signed by the atte in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, POLYCY THEMIA 1 XYes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? CORONARY ARTERY DISEASE 24a. Was an After this certificate has performe 2 No Yes 2 XNo 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗶 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending Natural
Accident Certificat death. 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director; of the Foundal of the completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 164395 DECEMBER 22, 2011

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State Registrar DANIEUÉ DEBETMAN, MD 6336

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CEDAR LANE

COLUMBA, MO 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ December 2011 9:20 A M Robel Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Gloria Friends Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 216-28-7854 82 **Director** 1 🛛 M 2 🗆 F November 23, 1929 Maryland Usual Residence of Dece 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at Director Maryland Baltimore Glen Arm 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21057 4608 Copperwood Lane Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No ö 1 X Never Married 2 Married by Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. If Yes, Give "natural", 3 - Widowed 4 - Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Inspector should be filed with and Mental Hygier? Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Estelle Eva Czarski Edward John Robel permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4608 Copperwood Lane Glen Arm Maryland 21057 William Robel/brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/28/11 Baltimore MD Most Holy Redeemen 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Signature of Funeral Service Licenses Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, i i.n. disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buris Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death the a P.O. t een signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Records. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy has certificate Yes 2 L Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 - Nursing Home 5 - Residence 6 Gother (Specify) askis ked living 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: A

completely filled in by the 1

State Registrar

Medical

29a. Certifier

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3 [ 29b. Signature and title of certifie

determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MD0067697

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MO

28f. Location (Street and Number or Rural Route Number,

12/23/

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 2:00 A M December George Bacon Rasin, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Edenwald Towson 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 219-03-4347 1 🕇 M 2 🗆 F **Director** May 28 1917 94 28a-f show "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Maryland n/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3104 Tilden Drive 21211 permit. Page 1 and 2 should be flied within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 X Yes 1 X Yes 2 Pool 1 45 Yes, Give 1941-45 Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) l_aw Judge Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bacon George Rasin Hortense Lieberman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3104 Tilden Drive, Baltimore, Maryland 21211 Gale Rasin / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State HilltopServiceCorp 12/24/2011 4 Donation 5 Other (Specify) |Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral 1050 York Road Towson, Maryland 21. Signature of Funeral Support License Home, 21204 Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-tran and Due to (or as a consequence attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pe 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has director, page 2 autopsy perform 2  $\square$  No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Deatl Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c 30. Name and addless of son who completed cause of death (Item 23a) (Type, Print)

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SUGGS Physician/ ESTHER MARGARET Month Day 12 22 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPICE BAUTIMORE GILCHEIST Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Hours 217-34-9434 Director 1 M 2 X F 13 MD 08/19 28a-f shov 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD BAYTMORE 1 Yes 2 No 10e. Street and Number 10q. Citizen of What Country? 23a Funeral 1020 €. 33 d ST 21218 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 ☐ Widowed 4 ☑ Divorced Specify: BLACK Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) BALTIMORE CA CROSSING GUARD 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ SILAS NORRIS ESTHER BURNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BELL (DAUGHTER SHARON 2857 W. COLDSPRING LANE - BALTO, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o Surial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, CARMEL CEMETERY 12/29/11 4 Donation 5 Other (Specify) BATTIMORE, MD of Funeral Service Licensee 22. Name and Address of Facility VAUGHN GREENE FUNERAL SVS PA 21. Signatur YORK ROAD. BALTIMUTE, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Schic disease or condition (a MEKIS Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-tran attending physician and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Was an autopsy performed? has certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2₹ No Other: 1 Tes 4 ☐ Nursing Home 5 ☐ Residence & Other (Specify) WSPUL 1 Inpatient 2 ER/Outpatient 3 DCA eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Acciden
3 Suicide 5 Pending injury after death. Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2 2011 Louise Irene Simpson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ale HOSDI ta timore ranklin Square Birthplace (State or Foreign Country) 4 Hrs 5. Social Security Number In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🙀 F 79 Director 232-46-1100 03/26/1932 West Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Medical Examinal must be notified at any injury or other traumatic event, the "Medical Examinal must be notified at once." Maryland Baltimore 1 ☐ Yes 2 No Essex Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 912 Frankewitz Road 21221 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify: à Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Elsie Cecil Harvey French 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8234 Kavanagh Road, Dundalk, Maryland 21222 Michael Allen French (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ¥38urial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 12/27/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21 Signature of Foneral Service Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause (Final **Physician** Ke. hronic dise e or condition resitting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? To the Hospital or Attending Physician; The After this certifiin funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation n 24 hours after death.

e Funeral Director: Afte bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State Registrar 31. Date filed (Month, Day

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

10067271

tarugooo Franklin Square Dr. Balto, MD21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 23a, perPHYS, G922, 12/27/2011, WS

State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ^{Day}2011 Year Physician/ 5:03 P M 24 Delores Faye Shue Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Carroll Westminster 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Days (Month, Day, Year) -13-1952 Country) 59 Months Hours Min 213-64-6476 Director 8 PA Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll 1 XYes 2 No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 112 S. Center St. 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify:white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife 9 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William H. Shue Dorothy Luckabaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Wright-friend 112 S. Center St., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) South Carroll Crem 12-30-11 Sykesville, MD 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home nomas 21157 254 Ε. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that successful shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) 107 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate outce. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 morths?
1 ☐ Yes 2 ☑ No Month 4 Pregnant a Pregnant at time of death ed by the a 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 11061/11 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of ause of 24a. Was an has autopsy prior to completion of death? ver say After this certificate ☐ Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No မြ 1 🗌 Inpatient 2 😡 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Suicide 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check rint)

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ri 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edwa - Dle -ingy Ó 4000019 31. Date filed (Month, Day, Year) State Registrar

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/Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death)				and	Chlordi	lazepo	xide	Intox	ication	Dea	th		
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Division of Vital Records, ral or Attending Physician: The law require rs after death.  al Director: After this certificate has been si led in by the finneral director, page 2 should be after the finneral director, page 2 should be after the finneral director, page 2 should be after the finneral director, page 2 should be after the finneral director, page 2 should be after the finneral director, page 2 should be after the finneral director, page 2 should be after the finneral director, page 2 should be after the finneral director, page 2 should be after the finneral director, page 2 should be after the finneral director, page 2 should be after the finneral director the finn	Certification:	3 Suicide 6 X Coul	d not be 28e. Place				, factory, office	building, et	c. 28f	Location (S or Town, St	treet and Number tate)966 Sar	or Rural Route Num	ber, City		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely illied in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Check only   Certifying Pi	hysician: To the best miner:On the basis of	f examination a											
F. W. G.	Σ	29b. Signature and title of certifie	and manner sta er	ateu.	7		29c. Licen	se number			29d. Date signed	(Month, Day, Year)			
		allle	UU	1 91		V	0.0	M.E.			December 2	4, 2011			
	Ī	30. Name and address of person Zabiullah Ali, M.D.	who completed cause Assistant Medica			W R	altimore Str	et Raiti	more Mr	21223					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2, Date of Death 3 Time of Death Day 22, 2011 Physician/ DECEMBER 5:25 A.M CAROLYN M. SMETON Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** TOWSON BALTIMORE GILCHRIST CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 3/3/1923 Days Hours 216-14-4899 88 **Director** 1 □ M 2**X** F MARYLAND 10d Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 XNo MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 47 THEO LANE 21204 or items 12. Was Decedent Ever in U.S. Armed Forces?_ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iter edical Examiner Black, White, etc. Yes 2 XNo 1 Never Married 2 Married Completed by 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates er than "natur , the Medical E 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. YEARS+ SOCIAL WORKER MEDICAL is marked other aumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en gonee. EDWARD BARTHOLOMAY LOUISE MUELLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL M. SMETON/SON 405 ABBEY CIRCLE ABINGDON, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12/23/2011 CATONSVILLE, MD 4 Donation 5 Other (Specify) METRO CREMATORY, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ovacular Disease Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of): resulting in death) Last the burial the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ģ in the past 12 months? 1 ☐ Yes 2 No Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No has page 2 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 Other: 1 Yes ospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 18211000 Suite 4105, Balthuell, MD 21204 Wilip Strateger, 6701 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 25 2011 Dec. 1:51A Florence C. Stephan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Golden Living Center Westminster 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 213-40-1769 **Director** 91 1 □ M 2 💢 F 2/19/1920 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carroll MD Westminster 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? mit. Page 1 and 2 should be filed within 72 hours after death with the satment of Health and Mertial Hygiene. optant: If item 27 is marked other than 'natural', or items 23a or injury or other traumatic event, the Medical Examiner must be a linjury or other traumatic event, the Medical Examiner must be a. Funeral 45 Timber Ridge Dr. 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Salesperson Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Chester Williams Dora Beard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1017 Gahle Road Westminster, MD 21158 Becky Owings-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date Burial 2 Cremation 3 TRemoval from State cemetery, crematory or other place) 12/29/11 4 ☐ Donation 5 ☐ Other (Specify) Kriders Cem. Westminster, MD 21. Sign turd / uneral Service Lice 22. Name and Address of Facility Fletcher Funeral Home, P.A 25.4 F. Main St. Westminster, MD 21157 nomas 254 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause un each line. Approximate Interval Between Immediate Cause (Final set and Death Physician mus disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of physician as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) the hed P.O. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed del 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s performed? Yes 2 No 2 🗌 No 1 Yes 24 hours after death.
Funeral Director: After this certific etely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ြု 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🏿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hou

To the Fune

completely fi 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ December 2011 25, 1937 Charla Jeanne Shumate Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Months Apr. 17, 1942 1 M 2 XF 214-42-4190 69 Yrs Director Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits notified 28a-f MD Laurel 1 X Yes 2 ☐ No Pricne George ᡖ 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? must be by Funeral 23a USA 20707 1015 Montrose Ave. Hygiene. other than "natural", or items ent, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 🖾 Married 2 🛛 No Yes Maryland 21215-0036 white 1 Yes 2 No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetologist Beauty traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ruth Eleanor Wills David Lyda Linard, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4812 Wicomico Ave., Beltsville, MD 20705 David L. Linard, II/ Brother Department of Health Important: If item 27 any injury or other trong once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, MD Ft.Lincoln Cemetery 2011 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Ken Ske M01053 313 Talbott Ave., Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Cardio-respiratory arrest Medical resulting in death) Due to (or as a consequence of) **Examiner** Pulmonary embolism Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of physician and the burial-transit Ovarian Cancer that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph for use as th IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 V Unknown signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4本 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed? Yes 2 No Physician: The 2XXNo 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 KNo Other: 1 🗌 Yes မ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1XXNatural (Month, Day, Year) 5 Pending M 1 Tes 2 No Investigation 2 Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 004695 of death (Item 23a) (Type, Print) 30. Name and address of person who cor

State Registrar

DHMH 17 Rev 7/2009

7300 VanDusen Road, Laurel, MD 20707

MD,

32. Regis rar's Signature

Sukhjit Singh Sidhu,

31. Date filed (Month, Day, Year)

Sleignt Esther

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			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 2											1	L	138			
	Physicia	n/	Decedent's Name (F		•	G1 ' 1						Date of Death     Month Day Year					e of Death		
	Medic	al	4a. Facility Name (if no	her Mcl			nt	T _{4b} Ci	Town or	r Location of	of Death	13 33 3011 3:02 11							
mad	Examin		Franklin					_		dale	or Death	Baltimor							
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	land show dat	to		b. County		10c. C							e City Limits						
	e Mary r 28a-f notifie	Director	MD  10e. Street and Number	Balti	more		Parkville						10-0	Mhat Co.		Yes 2 X No			
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36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ام	11. Marital Status  1 ☐ Never Married  3 ※ Widowed 4 □		Armed For 1 Tes If Yes, Give	1 Yes 2 VNo				ispanic Ori an, Mexicar Specify:	cify Yes or No Rican, etc.)	-	14. Race - American Indian, Black, White, etc.  Specify: White						
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Aary	should and N is ma		19a. Informant's Name				1.0	-				l Route Numb					2.4		
re, N	and 2 s Health Item 27 other tra		Mary Fr 20a. Method of Dispos		ugnc	20b.	Place of Disp	osition (/\	ame of	-		Edmon Date	<del>,                                    </del>			Town, State			
Baltimore,			1 ☐ Burial 2 ☐X 4 ☐ Donation 5	Cremation 3  Other (Specify	Removal from	State E	cemetery, cre vans F hapel-	matory o une:	rotherplac al Ain	ce)		26-11	1		-	ill,			
Balt	permit. Page Department of Important; If any injury or once,		21. Signature of Funer	al Service Licens	2001	1	2	2 Name	and Addre	ee of Facilit	hv.	apel Park	& Cr	ema	tio	n Ser	viæs		
of c	h sician/ Medical Examiner  portion and purial-transit	Sequentially list conditions, if any, leading to finn polate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											arrest,				mate Between nd Death		
Box 68760	The law requires that the death certificate be ate has been signed by the attending physici page 2 should be detached for use as the br	Physician/Medical	IF FEMALE:   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1										23d. Date of delivery Month Day Year			Year			
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Division of Vital Records,	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	l Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined M 1 Yes 2 Ni  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location City or To			er or Rui	al Route No	ımber,			
	Hospi 24 hou Funer etely fil	Medical	(Check 2	Certifying Phys Medical Exami	ner: On the basi	s of examination	on and/or inves	stigation,	in my opinie	on, death o	ccurred at	the time, date	and plac	e, and du	e to the o	cause(s) and	l manner state		
	To the within To the comple	Σ	only one) 3 L 29b. Signature and title	Certifying Nurs				$\overline{}$	gc. Licens		ite and pla	ace, and due to				s stated. , Day, Year)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year AM Reidar Jack Skille Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death Examiner Himore Franklin If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 1 JM 2 🗆 F Months Days Hours 81 Director 097-24-1136 1930 New York, MY Usual Residence of Decedent 28a-f show 10a, State 10b. County 10d. Inside City Limits items 23a or 28a-f shor ner must be notified at 10c. City, Town or Location Funeral Director Maryland Baltimore Parkville 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 United States 8810 Walther Blvd. Apt. 3514 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. Black, White, etc. ş 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Technical Writer Autoration Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Eleanor Theresa Puth Reidar Larson Skille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 Walther Blvd. Apt. 3514 Parkville, Maryland 21234 Anne Skille (Socuse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State December 29, Parkwood Cemetery Parkville, Maryland 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licensel 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 No Hospital ဂ္ဂ 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

3×

State Registrar Climus. Winsertint

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HIWOT 9000 FRANK

Square

10063327

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Baltimore MD 2123

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM# SperFH, G923, 1/3/2012, WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jane A. Sebald 2011 10:20A December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Towson Gilchrist Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1924 October 10, 1921 Maryland 7. Age (In yrs, last birthday) **Funeral** Days Hours Min Months Director 219-16-8341 1 □ M 2 🔀 F 87 Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County items 23a or 28a-f shoner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Parkville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 3333 Orlando Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 5 Completed by 1 Never Married 2 Married 1 Yes 2 No Specify "natural", 3 ▼ Widowed 4 □ Divorced Specify: White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Assignment Clerk C&P Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ပ္ Russell Glen Amanda Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Wilkins (Daughter) 5 Stewarton Court Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State December 27, Evans Funeral Chapel-Bel Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011  $\lambda$ ir ature of Ameral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MOXIE disease or condition resulting in death) brain dens Medical Due to (or as a consequence of): Examiner days ardiac an Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine My Umonia Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be phys use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 2 🗌 No Yes 2 No 1 Tes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Tes ဂ္ 4 Nursing Home 5 Residence 6 Wother (Specify) WOS 01 Q 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending nours after death.

neral Director: Af
y filled in by the ft 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 58303 December 24 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C CHAMISE NO 6701 N. CLUBES ST TONISEN MO 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State DEC 27 2011 Registrar

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ December 22 2011 1:35  $\mathbf{P}$  M Muriel Tyson Spagnolo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Forest Hill Senator Bob Hooper House If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) Ball Linore **Funeral** 218-03-3239 1 □ M 2 🗓 F **Director** 91 Yrs. 1920 02, Nov. Maryland Usual Residence of Deced 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Maryland Harford Bel Air 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 849 Cider Mill Lane 21014 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc ò à 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 🛮 Widowed 4 🗆 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Eliza Scheihing Edward Thampson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Diane Alsid (Daughter) 849 Cider Mill Lane, Bel Air, Maryland 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🏝 Burial 2 □ Cremation 3 □ Removal from State December 27, Parkville, Maryland 4 Donation 5 Other (Specify) Moreland Memorial Park 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — l 3 Newport Drive, Forest Hill, Maryland 21050 Signature of Funeral Service Licensee Jeffrey R. Testerman (M01543)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ENT Physician SIAGE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has perform within 24 hours after death.

To the Funeral Director: After this certificate I Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 1 Yes 4 Nursing Home 5 Residence မြ ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and Atle 29c. License number 29d. Date signed (Month, Day, Year) 8 ho completed cause of death (Item 23a) (Type, Print) 2300 Du 31. Date filed (Month. Day State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Henry Smith 732 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegheny Western Maryland Regional Medical Cumber1and If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 216-32-9513 74 **Director** 1 X M 2 □ F MD Nov 16 1937 Usual Residence of Dece 28a-f show 10a. State 10c. City, Town or Location permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** notified MD Allegheny Cumberland 1 🗆 Yes 2 💢 No 10e. Street and Numbe 10f. Zip Code ŏ 10g. Citizen of What Country? ms 23a or must be r 113 South Street 21502 USA items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces's 9 by 1 Never Married 2 Married X Yes 2 No Korea Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white "natural", Completed 3 Widowed 4 Divorced Year or Dates er than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) A & P Company heavy equipment operator tt of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Henry Smith Sr. Rose E. Hood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 South St., Cumberland, MD 21502 Dorothy Smith (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. All County Cremation | 12-26-11 Sykesville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Day Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): -transit and that initiated events resulting in death) Last Due to (or as a consequence of): burial physician the buria Physician/Medical 0 Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) signed by the attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Yes Cellulit 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has autopsy performed? Yes 2 \(\infty\) No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XVo Other: 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Natural Accident 1 Yes 2 No Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifiei Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Registrar
DHMH 17 Rev 7/2009

State

Date filed (Month, Day, Year)

DEC 2 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 10:50 P M 2011 Pauline B. Sendejo December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Marian Assisted Living Brookville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Hours 214-20-4403 **Director** Yrs Oct 7, 1925 Maryland 86 Usual Residence of Decede 28a-f shov 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f sho her must be notified at 10c. City, Town or Location Director 1 Yes 2 X No Maryland Brookville Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 19109 Georgia Avenue #218 20833 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No ò 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", If Yes, Give Specify: 3 Widowed 4 X Divorced White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ other traumatic Charles Browning Olivia Munsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other trau Lynne Sendejo / Daughter 11601 Elkin Street #204 Wheaton, MD 20902 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 12/27/2011 Woodbine, Maryland Final 21. Signature of Funeral Service Licer Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M MO1251 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pancreatic months Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 XNo Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 - Nursing Home 5 - Residence 6 X Other (Specify Asst Living Hospital 1 🔲 Yes 2 X No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5  $\square$  Pending death. 2 Accident
3 Suicide
4 Homicide Investigation Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours af er d

To the Funeral Direct
completely filled in by determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) December 23, 2011 D12121 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year DEC 2 7 2011

George Sengstack 3929 Ferrara Dr. Wheaton, MD 20906 32. Registraris Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death : 15 am **Physician** ONN 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner OakCrest Parkville Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 X M 2 □ F Months Days Hours Director 87 March 27 1924 MD 212-20-2506 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f show ed other than "natural", or items 23a or 28a-f show event, it would be an item of the retified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Blvd., #205 21234 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or ite 1 ∑Yes 2 No
If Yes, Give
Year or Dates: 43 '-46' 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: white ₫ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 C & P Telephone n/a Materials Management Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilbert Franklin Seitz Ada Pearl Miller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tranonce. 8820 Walther Blvd., #206, Parkville, MD 21234 Jeannette W. Seitz/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jessops Cemetery 12/26/11 Sparks, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
LO W. Padonia Rd., Timonium, MD 21093 21. Signature of Fun Michael 23a. Part 1. Enter the disease or complications that caused the shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner True to for an alex or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown signed by ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 pe 1 🗌 Yes 2 🔲 No 3 Probably 4 thknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 2 No 1 🗆 Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 1 ☐ Yes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After the funeral 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (tern 23a) (Type, Print) 2800 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ρ. Seifert Nancy December 2011 7:58 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Carrol1 Westminster Dove House Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours Min **Director** 1 🗆 M 2 🛚 F 300-58-3595 52 June 11, 1959 Germany Usual Residence of Decedent 28a-f shov ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MD Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 181 Far Corners Loop 21152 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Registered Nurse and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ John Walter Seifert Felicitas Penger other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health and : If item 27 is Mark A. Seifert Brother 3338 Lawndale Road Reisterstown, MD 20a. Method of Disposition 20b Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or c cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/28/11 4 ☐ Donation 5 ☐ Other (Specify) Saints Cemetery Reisterstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road 21136 Eline Funeral Home Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events and burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached for Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ TFUSIO Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed death? 2 1 No 1 🗌 Yes Yes 25. Was case referred to edical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □No မြ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work s after death.

I Director: Aff
d in by the fur 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined 24 hours after Funeral Direct letely filled in b Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completely fi (Check **Certifying Nurse** Practitioner. To the best of my knowledge 29b. Signature d title of certifier

5 V State Registrar ompleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Decembe Physician/ 3:50 pm Tyrone Stanley Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** more Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Unde **Funeral** (Month, Day, an 20, Country)unk Days Months 1 🛛 M 2 🗆 F Director 56 Jan  $\tilde{1}955$ -7083Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1XXYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 Funeral 905 Ellicott Dr. USA . Was Decedent Ever in U.S. Armed Forces? Unk
1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk Black White, etc. Completed by 1 Never Married 2 Married Specify: black 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation un 16b. Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prince Stanley - brother 905 Ellicott Dr; Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☒ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board ure of the eral Service Licensee Onald Shade, Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Wallo Medical Due to (or as a consequence of) Examiner MIC Sequentially list conditions. il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Day to I was a our record on of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician of for use as the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death Yes signed by the a 1 Yes 2 L g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be B examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital 2 🗆 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practions to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, h who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person filed (Month, Day, Year Registrar's Signature State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jordan G. Simpson Medical Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Spun IN)(COMICO a If Under 24 H 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth (In yrs. last birthday) **Funeral** Feb 28, 1926 1 🗆 M 2 🗆 F Months Min. Virginia 85 Yrs **Director** 218-20-7879 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland **Funeral Director** notified 28a-f 1 Yes 2 No MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P must be r USA 21811 26 Deep Channel Dr. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 No 1943-Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced 1946 the Medical 15. Decedent's Education (Specify only highest grade completed) unk 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 11 waterman event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic ever ပ Dolcie Louise Gill Jordan Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trat once. Mary Ann Simpson - wife 26 Deep Channel Dr; Berlin, Maryland 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 X Donation 5 D Other (Specify) ure of Fune al Service Licer 22. Name and Address of Facility State Anatomy Board de, Director 655 W. Baltimore St; Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cau se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
Penneral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ပ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signatur title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 63199 /17/n. 30. Name odress of person who completed cause of death (Item 23a) (Type, Print) 910

State Registrar 10

31. Date filed (Month, Day, Year)

SALISBURY

EASTERN SHORE

DHMH 17 Rev 7/2009

11-09641

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene George Shipe 41394 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 23, 2011 **Medical Examiner** 1818 hrs Robert Shipe George Wayne 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** Randallstown Northwest Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 6. Sex **Funeral** Months Days Hours Director Country) 213-42-4062 1 M 2 F 67 MD 30, 1944 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 V No Baltimore Owings Mills Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Healsh and Mental Hygenes.

The Healsh and Mental Hygenes and a statural", or items 23a or 28a-f sho and I. If item 27 is marked other than "natural", or items 23a or 28a-f sho and I filem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10e. Street and Number 5125 Deer Park Road 21117 USA 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes 4 X Divorced f Yes, Give Year 1 Yes 2X No specify 3 Widowed White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Construction Heavy Equipment Operator 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 01a Katherine Shipe Robert 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3007 Buffalo Road, New Windsor, MD John Wayne Shipe 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ortant: 7 12/30/11 Sykesville, Maryland Lake View Mem Park 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Medical Death aHypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of); if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) tran Physician/Medical AMENDED 23a,27,per me,g923 1-12-12 sm X UNPENDED attending physician or use as the burial -The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death Day Live birth 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ٤ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available pnor to completion of cause of autopsy has death? page ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) the Hospital or Attending Physician: Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other After this 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 Yes 2 No death. d in by the 2 Accident 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide 24 hours a Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOME December 24, 2011 O.C.M.E. JR. 30. Name and address of person who completed cause of death (Ifem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) DEC 27 gitrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Smith Yeur 19 45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Curroll trospital Center Westmin (ter Cerroll 5. Social Security Number 6. Sex 8. Date of Birth
(Month, Day, Year)
Jun. 17, 1925 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Days Maryland Director 220-40-8410 86 Jun. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f Maryland Carroll Keymar 1 ☐ Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2433 Francis Scott Key Highway 21757 U.S.A. er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1  $\square$  Never Married 2  $\square$  Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 XWidowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the cafeteria worker public school æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles E. Condon Hepsey Nickolson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Gary C. Smith/son 20 Memorial Dr. Taneytown, MD 21787 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Prospect Cemetery 12/27/2011 nr. Mt. Airy, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hartzler Funeral Home amarine 6 E. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ lostriclium disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Shorl Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of). attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia, Carcliomyopatny Records, 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 
Yes 2 
No 24a. Was an To the Hospital or Attending Physician: The law in within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 si autopsy performe Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes _2 X\No ည Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred e Hospina. In 24 hours after death. The Funeral Director: Aft Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0069086 December 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMARMA MD Curroll Hospital Center CHINTU 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 2. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ SANBORN 2:00PM DECEMBER TANILEY 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE n/a HARBOR HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Hours Feb 28, Months Virginia Director 212-50-2439 63 1 X M 2 - F Vrs Usual Residence of Dec r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director Baltimore MD n/a 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a ol must be Funeral U.S.A. 21230 1614 Jackson Street death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status "natural", or ite Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Auto/Truck Engines Mechanic other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) alth and Mental H

27 is marked of

r traumatic ever ပ e 1 and 2 should be of Health and Menta Gladys Sanborn, Jr. Η. Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8008 Camhill Dr., Rosedale, MD Mildred Plitt-ex-wife Department of Health Important: If item 27 any injury or other the once. Saltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln 1X Burial 2 Cremation 3 Removal from State 12/30/11 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. M 1050 York Rd.. Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER SMAL Ph. sician/ ION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events and burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL HIBRILLATION Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown PNEUMONIA 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?
1 ☐ Yes 2 ☑ No page 2 DIABETES: CLOSTRIDIUM DIFFICILE funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) ပု 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely

State Registrar

within 24 To the F

31. Date filed (Month, Day, Year) 27

ARIBIGBE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 🗆

only one) 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

29c. License number

RESO01

HARBOR HOSPITAL

29d. Date signed (Month, Day, Year)

DECEMBER 25 2011

3001 SOUTH HANOVER

STREET BALTIMOR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month below by Physician/ 05 Mary Ella Sevison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Cen. Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex **Funeral** Maryland 1 M 2 X F Months Days Min 214 26 5103 **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 507 Westway Road 21061 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2X No ş 1 Never Married 2 Married 1 ☐ Yes 2x No Specify. 3 Widowed 4 ☐ Divorced Specify White Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarence Harris Nellie Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21061 507 Westway Road Mary Moore / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/16/2011 Crestlawn Cemetery Marriottsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one causi Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) r as a consequence of): Examiner So quantitally list or in little as Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Box Live Birth 2 Fetal death
Pregnant at time of death 3 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day detached ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 🗌 No 1 Yes Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Funeral Director: After thi completed filled in by the funeral Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Contifying Nurses Fractioner: To the best of my knowledge, destill and with time, date and plans, and dust of the cause(s) and manner as status 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ OSE IF GEL 2011 :57A 10 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner N/ABALTIMORE SINAI HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday) Days Hours (Month Day Year) 23 Country) 1 M 2 F MD Director 217-16-1544 88 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a Funeral USA 3420 ASSOCIATED WAY, #202 21117 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ō 1 Never Married 2 Married à Maryland 21215-0036 72 hours after 1 🗆 Yes 2 🔀 No Yes, Give Specify "natural" 3 Divorced 4 Divorced Completed Year or Dates WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER 12 OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be WOLF SAMUEL ESTHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau ALBERT SIEGEL / HUSBAND 3420 ASSOCIATED WAY, #202, OWINGS MILLS, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State BETH EL MEMORIAL PARK: 12/23/2011 4 Donation 5 Other (Specify) RANDALLSTOWN, MD 21. Si Service Licens 22. Name and Address of Facility SOL LEVINSON &BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EPSIS 'iysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Éxaminer NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has t page 2 s performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 No After this certification funeral director, p 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ည 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: A: completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie

State Registrar

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31. Date filed (Month, Day, Year)

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CTR 2434 W. BELVEDERE AVE BALTIMORE MB21215

HYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ISAB #TUNDE

BREW

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 10.10 0 Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) If Unde **Funeral** (Month, Day, Year) Months Hours Min Director 1 ☑ M 2 ☐ F MD 25 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 10b. County Town or Location Director 1 Yes 2 No items 23a or 10e. Street and Numb 10g. Citizen of What Country? Funeral 1133 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. ō 1 Never Married 2 Married 9 2 No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry SOCIAL Il Hygiene. We. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit, Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Şurname) ဂ 19a. Informant's Name/Relationship (Type, Print) or Town, State, Zip Code, 19b. Mailing Address (Street and Number or Rural Route Number, City 5MD21117 4650 Kiverston 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location any injury or Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service nicens Funeral Services 22. Name and Address of Facility 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, shock, of Heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine ue to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 attending p IF FEMALE ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consequent et time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant Box ( in the past 12 months? Month Day Year 1 Yes 2 No ed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed der γ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be director, page 2 s autopsy performed? Yes 2 \( \subseteq \text{No.} \) of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes ျှ 2 XNo 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Division s after death.

I Director: After the second in by the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in the fundamental in 1 Yes 2 No Accident Suicide Investigation 6 Could not be within 24 hours after dear To the Funeral Director completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Tokoly Rita Eileen Jacklynne Physician/ December 23, 2047 5:05 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Kris - Leigh Assisted Living Anne Arundel Gambrills If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number 102 - 18 - 2645 **Funeral** 1 - M 2 - F 07/24/1920 91 Yrs **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Gambrills Anne Arundel 1X Yes 2 No 10e. Street and Number 1032 Annapolis Road 10f. Zip Code 21054 ō 10g. Citizen of What Country? 23a Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. er than "natural", or the Medical Examin ρ 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) Coilege (1-4 or 5+) Sales Associate Retail Be 17. Father's Name (First, Middle, Last)
John Tokoly 18. Mother's Name (First, Middle, Maiden Surname) မ Stansensky Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16006 Pond Meadow Lane, Bowie, MD 20716 |Barbara Brisso / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State Chesapeake Crematory 12/27/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baitimore, MD 21203 21. Signature of Funeral Service Licensee DOMOta Marshall Llaishow 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ dementi disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L
9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons Yes 2 X No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 X No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R143194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. #G LINGSTEWN MD 21090 Digital

Registrar DHMH 17 Rev 7/2009

State

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Baltimore, Maryland 21215-0036

Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per th g923 1-4-11 vt
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Edwards Thomas Ruth December Physician/ 26, 2019 10:45 AM Medical _____ County of Death Prince George's 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3311 Rhode Island Avenue #311 Mt. Rainier If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Social Security Number 498-20-8649 Days Hours CountrOklahoma Months 1 M 2 XF 09/25/94/94 97 Director Usual Residence of Decedent 10c. City, Town or Location Mt. Rainier 28a-f shov aţ 10a. State 10d. Inside City Limits Director Prince George's MD be notified 1X Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20712 items 23a 3311 Rhode Island Avenue #311 USA **Examiner must** 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ori à 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes X No Specify. Black Specify: "natural", 3 ¥ Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Healthcare Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin W. Edwards Sleet ၉ Aszzeal Bridgett 19a Informant's Name/Relationship (Type, Print) P.S. Opiotennione / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3311 Rhode Island Avenue, #311, Mt. Reinier, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 12/28/2011 Beltsville, MD Chesapeake Crematory 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility}
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service License Dorota Marshal 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Pancreatic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death detached 9 Unknown the signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Breast Cancer 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 ☐ Yes 2 ☐ No Yes 2X No After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🔀 No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 1 🗶 Natural 5 Pending within 24 hours ar er death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jacelyne wucethou, m) D63748 December 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou, MD, 201 E. University Pkwy, Baltimore, MD 21218 State backer Registrar

State of Maryland / Department of Health and Mental Hygiene 2 \(\int\) 41402 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month DEC 6:30 AM LINE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSPITAL BALTO MORE SECOURS 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year nk 1 □ M 2 💢 F Days Min Unk 65 MD Director Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Baltimore MD 1X Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be 21216 USA Funeral 3210 Westwood Ave 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Yes 2X No Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Counselor Reflection Center other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Ruby Taylor Henry Mills traumatic Page 1 and 2 should ment of Health and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3210 Westwood Ave Baltimore MD 21216 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lydia Mills Aunt Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem 12/26/11 Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge RD Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final LUNG CANCER Onset and Death Physician/ METASTATIC disease or condition Medical resulting in death) RUCTIVE PULMONA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine NEH MONIA To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Box 68760 for use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2 s 1 Yes 2 No 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation completed filled in by the 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0030355 KORuth DECEMBER 18,2011 30. Name and address of person who completed cause of beath (Item 23a) (Type, Print) SECOURS HOSPITAL BON Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 12, 2014 11:22 Warren Charles Todd Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. 6. Sex 1 ፟ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Ju^{Month} 1^{Day, Year)} 938 Ohio Director 212-34-4155 73 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗆 Yes 2 🔀 No Cecil Elkton 10g. Citizen of What Country? 5 10e. Street and Number 10f. Zip Code 137 Old Chestnut Rd. 21921 "natural", or items 23a 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 1 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 0 technician telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Warren Charles Todd Sr. Anna Mae Lenyo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Deportment of Health ar Important: If item 27 is any njury or other trau Ann N. Todd - wife 137 Old Chestnut Rd; Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Qther (Specify) Signature of Funeral Pervice Licensee Ronald S Wade 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or iinjury that initiated events burial-trar resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) Certificate: To 2 🗐 🎾 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) 50 31. Date filed (Month, Day, 32 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

17/34

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	for State Registrar				tificate of E		Re	g. No. 201	144	
cian/		ence Tindall					2. Date of Death Month Novembe	Day Year	3. Time of Death	
niner	4a. Facility Name (if not institu	tion, give street and number)				Location of Death		4c. County of De	ath	
	Laurelwood  5. Social Security Number	Care Center	ge (In yrs. la:	et hirthday)	Elkton If Under 1 Year	If Under 24 Hrs.	B. Date of Birth	Cecil	irthplace (State or Fore	
ral or	1 M 2 XF 72 Yrs. Months Days Hours Min. (Month, Day, Year) Residence of Decedent Yrs.									
ō	10a. State 10b. Cou	inty	10c. City,	, Town or Loc	cation				10d. Inside City Lim	
rect	MD Ce	eci1	E1	kton					1 □ Yes 2 🔀	
Funeral Director	10e. Street and Number  1 Cherry La	ine			10f. Zip Code 21921		10	ng. Citizen of What C USA	Country?	
þ	11. Marital Status 1 ☐ Never Married 2 ☐ i 3 ☒Widowed 4 ☐ Divor	If Ven Chin	?	l I		spanic Origin? (Speci n, Mexican, Puerto Ri Specify:		14. Race - An Black, Wh Specify: Wh	ite, etc.	
olete	15. Dec	edent's Education ighest grade completed)			lent's Usual Occupa	ation Juring most of working		6b. Kind of Busines	s Industry	
Completed	Elementary/Seconday (0-1	<del> </del>	5+)	life. D	amstress	uning most of working		clothin	ng	
Be	17. Father's Name (First, Midd	lle, Last)				18. Mother's Name (	First, Middle, Ma	aiden Surname)		
욘	Hugh Marte					Gladys I	Emmaline	Welch		
	19a. Informant's Name/Relation  James Troy				•	,	Number, City or Town, State, Zip Code) ryland 21921			
	20a. Method of Disposition  1  Burial 2  Cremat  4  Donation 5  Oth	tion 3 Removal from States (Specify)			sition (Name of natory or other plac	e) Da	te 2	20c. Location - City	or Town, State	
)ce	21. Signature of Funeral Servi		<u> </u>			s of Facility Stat		-		
9	sonns	UIN			655 W. Ba	ltimore S	t; Balt	imore, MD	21201	
n/ cal er	23a. Tr 1. Enter the disease shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	ist only one cause on each li	a conseque	ence of):	SION	g, Such as cardiac or	еѕрпаюту апес		Approximate Interval Betweer Onset and Death	
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à	Part II. Other significant con-	ditions contributing to death	but not resu	nderlying cause giv	en in Part I.			to the cause of death		
Completed	24a. Was an autopsy priority performed dec									
	25. Was case referred to predi	cal			26 Pis	ace of Death (Check o	1 Yes 2	No 1 Y	′es 2 □ No	
To Be	examiner? 1 Yes 2 No	Hospital:	tient 2 🗆 E	R/Outpatien	ot 3 DOA Othe	r.		nce 6  Other (Sp	ecify)	
	27. Manner of Death  1 Natural 5 Pe 2 Accident Inv.	28a. Date of in	ury 2	28b. Time of injury	28c. Injury work	at 28		v injury occurred		
al Certificate:	3 Suicide 6 Co	ermined 28e. Place of Ir building, e	tc. (Specify)		eet, factory, office	28	City or Town,			
Medical	(Check 2 L Medic	ying Physician: To the best of al Examiner: On the basis of ying Nurse Practioner: To the	examination	and/or invest	igation, in my opinio	n, death occurred at the	ne time, date and	place, and due to the	e cause(s) and manner	
	29b. Signature and title of dertifier 29d. Date signed (Mo									
	1 U				000	7174	TI	2/15/0	2011	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Physician Medica Examine **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 5:15 а.п. Baltimore, Maryland 21215-0036 **DECEMBER 21, 2011** Physician/ Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 GILBERT URBANSKI

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		(First, Middle, Las	st)							2. Date of De	ath		2 1	3.	Time of	Death		
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	ella N		street and numb	er)		4b. City, Town, or Location of Death <b>Timonium</b>					imo							
215	Security Nur -30-95	534	ex 7	'. Age (In yrs. la		If Unde Months	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year Aug. 25, 19					9. Birthplace (State or For Country) Maryland						
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	et and Numb	oaz Road				10f. Zip Code 21234						itizen of \ US		ountry?				
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1 🗆 N		d 2 🛚 Married	Armed Forc 1 🔼 Yes If Yes, Give Year or Date		- 1		2 X No			nicari, etc.		Specify	k, White Wh	e, etc. lit∈				
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19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rur</i>															)			
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Immedia disease resulting Sequent if any, le- cause (I that initia	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final sease or condition sulting in death)  Due to (or a a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):													erval Betv				
in th	LE: s decedent p ne past 12 m l Yes 2 l Unknown	onths?	23c. If yes, outco 1 ☐ Live Bi 4 ☐ Pregna 9 ☐ Unkno	irth 2 🗌 Feta ant at time of c	l death 3	Ectopic Other (s _f		23d. Date o Month										
Part II. O	ther signific	eant conditions of	ontributing to dea	ath but not res	ulting in the u	nderlying	cause given	in Part	1.	23e. Did t		use cont No				eath? Unknown		
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3 🔲 🤄	Accident Suicide Homicide	Investigation 6 Could not be determined	ρ	me, farm, stre	M eet, factor		·S 2 L	INO	28f. Location (\$ City or Tov			er or Ru	ral Rou	te Numb	er,			
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	nature and tij		(AN	0		ge, death occurred at the time, date and place, and due to the 29c. License number 29						29d. Date signed (Month, Day, Year)						
	e and address	6	completed cause	of death (Item	,	,	RD.	TIMO	) NIU	M, MD 2	1093	<del>' ' </del>		<b></b>				
31. Date 1	filed (Month,	Day, Year)		gistra 's Signa									-					

State

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State	State of M	aryland		partment of F		Mental Hy	/giene	9		
		Registrar  1. Decedent's Name (First, Middle, Las)	<i>t</i> )			ertificate of L	<i>Death</i>	2. Date of D	Reg. N	<u>·201</u>	2 Time 2	4116
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Examin	er	4a Facility Name (if not institution, give	street and number)			SYKE	Location of Death	e	40	Carr	eath O	
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show at	'n	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or	Location					10d. Inside C	ity Limits
Maryla 28a-f	Funeral Director	MD Carro	11				esville					s 2 <b>X</b> No
ith the	ralD	10e. Street and Number				10f. Zip Code	1784		10g. C	itizen of What	Country?	
eath w	-une	710 Obrecht Road  11. Marital Status	12. Was Decedent	Ever in U.S	. 1	3. Was Decedent of H If Yes, specify Cuba		pecify Yes or No	-		merican Indian,	
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l be filed fental Hy rked oth tic event	To Be	17. Father's Name <i>(First, Middle, Last)</i> Thomas Benton S	Stall Fowl	ler, S	Sr.		18. Mother's Nar Mary I	ne <i>(First, Middle</i> Louise \				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty Mr. Paul A. Capri		utor)		ailing Address (Street a						
e 1 and of Hea if item ir othe		20a. Method of Disposition  1 🕅 Burial 2 🗆 Cremation 3 🗀	Removal from State		lace of Di	sposition (Name of crematory or other place		Date			or Town, State	
it. Pag irtment irtant: irjury o		4 Donation 5 Other (Specify	y)	Mo	re1a	nd Mem. Par		30/2011		ltimore		T D4
permi Depar Impol any ir		21. Signature of Funeral Service Licer's Duan L Ho	ught M	0076	64	22. Name and Addres					£ & CHAPI	SL,PA
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ath certifi attending for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								23d. Date of delivery Month Day		
at the de d by the	Phys	9 ☐ Unknown  Part II. Other significant conditions co	9 Unknown	out not resu	ulting in th	ne underlying cause giv	ven in Part I.	23e. Did	tobacco	use contribut	e to the cause of	death?
requires that the been signed by t should be detach	ed by	]									Probably 4	
e law req e has bee ge 2 sho	Completed							per	opsy form <u>ed</u> ?	prior deat	autopsy findings to completion of h?	
Physician: The law this certificate has all director, page 2 s	Be Co	25. Was case referred to medical		<u> </u>		26. Pl	ace of Death (Che		2 🗆 1	No. 1 L	Yes 2 No	
hysici this ce al direc	မ	1 L Yes 2 L No				atient 3 DOA Oth	4 LY Nursing F	Home 5 Res			pecify)	
ending Fath. or: After the funera	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		iry y, Yea <i>r</i> )	28b. Tim injui	y work		28d. Describe	how inju	iry occurred		
al or Attus after de Il Directo		3	28e. Place of Inj building, et			street, factory, office		28f. Location City or To			Rural Route Num	ber,
To the Hospital or Attending Pt within 24 hours after death.  To the Funeral Director: After th completed filled in by the funeral	Medical		ner: On the basis of e	examination	and/or in	th occured at the time vestigation, in my opinione, death occurred at the	on, death occurred	at the time, date	and plac	e, and due to	the cause(s) and m	anner stated
To th To th Comp	_	29b. Signature and title of certifier	0,		- 0	29c. Licens		7	29d. D		onth, Day, Year)	) ] ]
OW		30. Name and address of person who c		leath (Item	23a) (Typ	e, Print) 710	Objec	h+ Rd			1 20	11
Stat	e.	31. Date filed (Month, Day, Year)	2 e e r	er's Signat	ure	Jy k	ezsvill	e MI	) 2	1784		
Registra		ner o 7 2	011		1	Soule						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41407 1 - For State Registrar Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death 24, Physician/ Month 2011 Nichlaus Thomas Von Hagel, Jr. December 1:21 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Columbia Howard Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 220-60-9720 1 **X** M 2 □ F Aug 24, 1951 Usual Residence of Decedent 60 Maryland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Columbia Howard 10e. Street and Number ò 10g. Citizen of What Country? ral", or items 23a or Examiner must be a 5011 Green Mountain Circle, Unit 2 21044 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 nan "natural", o Medical Exan 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Completed Caucasian Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 4 Certified Public Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file lith and Mental I 27 is marked o r traumatic eve မ Nichlaus Thomas Von Hagel, Sr. Mary Loretta Johns 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is a any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Tierney Von Hagel / Wife 5011 Green Mountain Circle Unit 2 Columbia, MD 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 12/27/2011 Woodbine, Maryland Final 21. Signature of Funeral Service Licensee Coing Home Cremation Service P.O. Box 784 -MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final NCN - SMALL ČELL
Due to (or as a consequence of): Physician/ LUNG disease or condition resulting in death) 2010 Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of, cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death g Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 

✓ Yes 2 

No 3 

Probably 4 

Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) #CSFICE မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 164395 DECEMBER 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA, MD 21044 CEDAR LANE DANIEUE SOBERMAN, MID 6336 1. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [ State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vo_{1z} Thelma Ε. Dec. 2011 21 12:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Senator Bob Hooper House Forest Hill Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2,15gm Min. Hours Director 218-26-4435 1 ☐ M 2X☐ F 82 Oct. 2,1929 Maryland Usual Residence of Decede 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 XNo Bel Air MD Harford "natural", or items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 404 Aggies Circle Unit A 21014 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Black, White, etc. by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give 3 XWidowed 4 Divorced White Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 6 Years Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Emma Biggins Howard M. Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra 404 Aggies Circle Unit A Bel Air, MD Robert W. Volz 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/28/2011 Baltimore, Maryland Gdns. of Faith Cem 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licer Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line. Immediate Cause (Final Onset and Death STAGE Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 No ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence filled in by the funeral Manyler of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) 2011 ss of person who completed cause of death (Item 23a) (Type, Print) 2300 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 N State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 20, Wright Mathews 20°I'1 4:05 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth April Day, Year) April 5, 1939 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1 M 2 X 72 Philippines Director 399-40-6408 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Montgomery Village 28a-f MD Montgomery 1 Tes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 19379 Keymar Way 20886 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2X No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H ၉ of Health and Menta fitem 27 is marked rother traumatic en Scott Heistand Mary James Joseph Mathews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of item 27 i William H. Wright / Husband 20886 19379 Keymar Way, Montgomery Village, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a 1 ☐ Burial 2 【X】 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or ò Beltsville, MD Chesapeake Crematory 12/22/2011 Signature of Funeral ervice Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
ON Month Immediate Cause (Final Ph_si_ian/ disease or condition Medical resulting in death) Examiner tate Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exam burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 as the b IF FEMALE: nse 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Ectopic pregnancy Month Dav 5 Other (specify) Pregnant at time of death signed by the a g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been signompleted filled in by the funeral director, page 2 should by 1 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Thromasses Of legs. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ✓ Natural injury work? 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

HIROBERT BIR 31. Date filed (Month, Day, Year) **DEC 2 7 2011** State Registrar

29b. Signature and title of certifier

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/ RUSSELL AVENIUE

29c. License number

04115

GAITHERSDURG, WLD

29d. Date signed (Month. Day, Year) Scenber 20, 2011

20877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month 12 La Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Spuntry) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗹 F 203 65 **Director** 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No mo5 10e, Street and Number 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. "natural", or ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1) me 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) North 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Baltmore, tem Name and Address of Facility Funeral Service Licensee ral Home, P.A. any 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Preumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🔀 No Day Year detached 9 Unknown Records, P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kidney 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Nc page 2 **N**No 1 Yes Division of Vital 25. Was case referred to medical Be funeral director 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 💆 No Other: 욘 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending injury s after death. 1 Tes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and AU417643 30. Mame and address of person who completed cause of death (Item 23a) (Type, Print) e mar

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND FIEM#8PerFH, G924, 2/6/2012, WS

State of Maryland / Department of Health and Mental Hygiene 2 | | | For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ROBERT BRENT WHITEHEAD December 2011 17:45 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Gilchrist Hospice Columbia . Social Security Number 8. Date of Birth (Month, Day, DCC • 2.2 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 217-58-2592 59 XXM2DF Maryland Mar. 16, 1952 Usual Residence of Decedent or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 1 Yes 2xx No Maryland Howard Laurel 10e. Street and Numbe 10f. Zip Code 10q. Citizen of What Country? 23a Funeral 10434 Shady Acres Lane 20723 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or ρ 1 Never Married 2 Married 1 ☐ Yes ※XX No If Yes, Give Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes XX No Specify. "natural", Specify: Completed 3 Widowed 4 X vivorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Grade 12 Building Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Whitehead Gladys Poe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Whitehead, Jr. 10434 Shady Acres Lane Laurel, Maryland 20723 son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 12/28/2011 4 Donation 5 Other (Specify) Emmanuel Cemetey Laurel, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility P.A. Donaldson Funeral Home, P.A. 40 M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, or co plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Ph sician/ TONSILLAR disease or condition resulting in death) CANCER MARCH 2010 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ó Day Month Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performe 2 No Yes 2 X No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗶 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA this ( 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director; After 1 X Natural (Month, Day, Year) injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 164395 DELEMBER 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANE COLUMBIA, MD 21044 10 DANIEUE DOBERMANIMS 6336 32. Registrar's Sanature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William Magruder Waters December 2011 9:20 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Oak Crest Care Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Date or Day, Year) (Month, Day, Year) 28,1925 Days Kobe, Japan 1 ₹ M 2 □ F Hours 86 Director 220-16-2514 **August** Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Parkville Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral United States 8800 Walther Blvd. Apt. 2301 21234 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Federal Government <u>Electrical Engineer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harris Waters Virginia Mosley injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important; If item 27 is any injury or other trau 5126 Buttermilk Road Pylesville, Maryland 21132 William Waters (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date December 20, Evans Funeral Chapel-Eel Forest Hill, Maryland of Funeral Service Lice Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. diate Cause (Final Onset and Death Ph, ici, n End ase or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Examine Due to (or as a consequence of) dy. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the 687 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the a signed by t be detach Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Demental 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital or filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who complete Alice M BRAZIEL mplet cause of death (Item 23a) (Type, Print) Walther Blod Parbrille, MD. 21234 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

20 Rr

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene 2011 1, 1, 1, 1															
		1 - For State of Maryland / Department of Health and Mental Hygiene 20   4   4   4   Certificate of Death Reg. No.														
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	Physicia Medic		Cathe	mhe W	1) Kerson	0				Month December	Day	22,2		3. Time of D		
مجسد	Examin	er	4a. Facility Name (if not institution	1 Habital C	enfer			esm	insper	/		County o	1011			
L	Funeral Director		5. Social Security Number 218-06-5413	6. Sex 7. Age 1 M 2 X F	e (In yrs. last birt 43	thday) Yrs.	If Under 1 Year Months Days	Hours	r 24 Hrs. Min.	8. Date of Bi	rth 25 , Yea <i>r)</i> 16 , 1	968	9. Birthp Count	elace (State or F (ry) OH	Foreign	
	and show fat	or	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	ation						11	0d. Inside City	Limits	
	Maryl 28a-f otifiec	10a. State   10b. County   10c. City, Town or Location   New Windsor   10c. City   10c.												1 🗌 Yes 2	<b>X</b> □ No	
	ith the 23a or st be r	ral	10e. Street and Number 3020 Buffalo	Road			10f. Zip Code	776			10g. Cit	izen of Wh	hat Coun USA	try?		
	tems ?	Funeral	11. Marital Status	12. Was Decedent B	ever in U.S.	13. W	as Decedent of H		rigin? (Spe	cify Yes or No	-	14. Race		an Indian,		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mertal Hyglene. Department of Health and Mertal Hyglene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show min injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 XMar	If You Give	No		Yes, specify Cuba			Hican, etc.)		Black, White, etc.  Specify: White				
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2	1 and 2 sh of Health ar f item 27 is other trau		Mr. Frederick	(Spc	usc / I		g Address (Street ) Buffalo ]									
Baltimore,	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1  Burial 2  Cremation	3 ☐ Removal from State	cemete	ry, crem	ition (Name of atory or other plac			Date	l .	ocation - C	-			
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928	rtificate ing phy e as th	/Med	IF FEMALE:													
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be evitin 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome  1  Live Birth  4  Pregnant a  9  Unknown	2 - Fetal death		Ectopic pregnand Other (specify)	су			3	23d. Date Mont		ery Day Yea	ar	
P.0	that th ned by e detac	by Ph	Part II. Other significant condition	ons contributing to death b	ut not resulting	in the ur	derlying cause gi	ven in Par	t I.	23e. Did	tobacco u	se contrib	oute to th	e cause of dea	th?	
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Žį.	Physician: The law this certificate has ral director, page 2 s	To B	exampler?		ent 2 ER/OL	utpatient	LOth	er: _		me 5 🗆 Res	idence 6	☐ Other	(Specify)	)		
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	e Hosp 24 ho e Fune deted f	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of each Nurse Practioner: To the	kamination and/c	or investi	gation, in my opinio	on, death o	occurred at	the time, date	and place	and due t	to the cau	use(s) and mann	er stated.	
	No the within To the comp	only one) 3 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)														
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	130		30. Name and address bi-person	who completed cause of de	295 S	Type, Pr	/ A /	54)	30	J W	2) JM.	insper		ron 2	7157	
精	Stat	е	31. Date filed (Month, Day, Year)		r's Signature	B	ulas									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g923 1-3-12 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar 4 | 4 | 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day CLAIRE ANN WILLIAMS 2:13 PM DECEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 070502 SAINT JOSEPH MEDICAL CENTER 8. Date of Birth (M2nth, Day, Year) 01/<del>20/</del>1947 Birthplace (State or Foreign Country) 6. Sex If Under 24 Hrs **Funeral** 213-52-7807 1 □ M 2**X** X F Director 64 Maryland fshow 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at Director 1 Tes 2 XIXVo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8615 Drumwood Road 21286 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r Race - American Indian. Armed Forces?

1 Yes XX No Black, White, etc. þ 1 Never Married 2 XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Education other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Milton Conaway Mary Anna Mainster and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Robert Williams Husband 8615 Drumwood Road Towson, Maryland 21286 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. XBurial 2 Cremation Dulaney Valley Mem Gardens 12/24/2011 Donation 5 D Other Specify) Timonium, Maryland ire of Funeral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, o complication shock, or heart failure. List only one calls is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death e on each line Immediate Cause (Final disease or condition Physician/ INFARCTION VENTRICULAR SEPTAL 16 HOURS Medical resulting in death) Examiner ANTEROSEPTAL MYCCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or in that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Vear 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 X Yes 2 □ No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date/signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 7601, USLER DRIVE FINNEY, TOWSON, MARYLAND 21204 32. Registra s Sign Registrar

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Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12&19b Per FH G923 1/03/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 5:24 P M Robert A. Woods December 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 034-22-2118 Director 1 X M 2 D F 80 June 3, 1931 Massachusetts Usual Residence of Decedent 28a-f show 10d. Inside City Limits notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be n Funeral 10401 Grosvenor Place #1702 20852 United States items death 12. Was Decedent Ever in U.S. Armed Forces? 53–55 1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. o þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 nan "natural", Medical Exan 1 ☐ Yes 2 X No Specify: Specify: White Year or Dates. 54-55 Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) 721 (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "ı College (1-4 or 5+) 5+ Elementary/Secondary (0-12) the Communications Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frederick E. Woods Edna Pearl Cottle traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10401 Grosvenor Place # 1702, Rockville, Maryland 2005 1 and 2 s of Health item 27 i Betty L. Woods / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of December 26 20c. Location - City or Town, State Montgomery or other place) Crematorium, Inc. permit. Page 1
Department of I
Important: If it
any injury or o of ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Bethesda, Maryland 4 Donation 5 Other (Specify) 2011 21. Signal re o Fut anal Service ceneed 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading controlled cause. Enter Underlying Cause (Disease or injury Dise to for so a concequence of) Examir that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sion of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page, perform death? certificate 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No 1 🗌 Yes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident M Investigation within 24 hours after deatl To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Hospital or At 24 hours after o determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1026 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 Anitha Pesala Chetty, State DEC 27 2011 Registrar

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State Registrar 228

ompleted cause of death (Item 23a) (Type, Print

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31, Date filed (Mon#) Say, Year,

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Physician ledical Examine	1/	<ol> <li>Decedent's Name (First, Middle,L</li> </ol>	•	R.	Will	iams		2. Date of De Month	ath Day Yea er 16, 2011		3. Time of Death 0312 hrs
		4a. Facility Name (if not institution, g Johns Hopkins Bayview	ive street and number	)		4b. City, Town, or Baltimore	Location of D		4c. County of	of Death	
Funeral Director		5. Social Security Number 6. 217-78-6722	Sex 7. Ac	ge (In yrs. i	last birthday) Yrs	If Under 1 Year		Min.	20,1960	9. Birth	
r any	ł	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City	, Town or Locat	ion				- 1	10d. Inside City Limits
aryland 8a-f show any at once.	힕.	Bal 10e. Street and Number	timore			10f. Zip Code	Dun	da1k	10g. Citizen of Wh		1 Yes 2 No
the Ma	2 2	6814 Holabird	Avenue				222		United		
Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Intt. If item 71 is marked other than "matural", or items 23a or 28a-f she or other transmitte event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Marrie	1 Yes 2			es, specify Cuban	, Mexican, Pu	( Specify Yes or Nerto Rican, etc.)	White	e, etc.	an Indian, Black,
ours after		3 Widowed 4 Divorce  15. Decedent's Education (Specify	ed If Yes, Give Year or Dates: only highest grade cor	npleted)		Yes 2 No	ion (Give kind		Specify:		ite dustry
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours a ment of Realth and Mental Hygiene fants: Hitem 27 is marked other than "natural or other trannafte event, the Medical Examination of Communication In Description of the property of the Medical Examination of the Communication In To Description In Inc.	Completed	Elementary/Secondary (0-12)  12 Years	College (1-4 or	5+)		ost of working life. sab1ed	DO NOT use	retired)	N/A		
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical To Bo Comment		17. Father's Name (First, Middle, Las	,					ame (First, Middle 1ian Mil	Maiden Surname)		
2121 tould be fi and Mental I is marked tic event,	<u>-</u>	George William: 19a. Informant's Name/Relationship	(Type, Print )			,	t and Number	or Rural Route Nu	ımber, City or Towr		'
and 2 sho lealth and tem 27 is traumati	- 1	John Williams  20a. Method of Disposition	(Brother)		Place of Dispos	ition (Name of cer		Road Du	ndalk, Ma		and 21222 Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	ļ	1 Burial 2 X Cremation 3 4 Donation 5 Other Specia			crematory or oth		Corp. 1	2/23/201	1 Baltin	nore	, Maryland
Baltimore, ME permit. Pages 1 and 2 s Department of Health at Important: If item injury or other traumz	- 1	21. Sign w of Funeral Service Lice	2 / /	)	22. N Dt 1.79	lame and Address ida-Ruck 22 Wise	of Facility Funera	.1 Home o	f Dundall Marvland	k, I	nc. 222
Physician // /Medical		23a. Fart I. Enter the disease, in confailure. List only one cause on	nplications that caused each line. aMixed drug								Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons			e and bi	phenny	dramine	Incomica		Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence o	of):					$\dashv$	
ed nsit		(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence o	f):					$\dashv$	-
e be executed sician and burial - transit	- -	▼ UNPENDED	AMENDED 23a	a,pt.	11,27,2	8a-f,per	me,g9	24 2-23-	l2 sm		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physician and appletely filled in by the funeral director, page 2 should be detached for use as the burial - transfilled Centrification: To Re Commissed by Physician Medical Edical		F FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor  1 Live birth  Pregnant at	, -	2 Fe	tal death 3 [	Ectopic pre	gnancy	23d. Date of o	delivery Da	ay Year
D. Bo	Š	1 Yes 2 No 9 Unknow  Part II. Other significant conditions	9 Unknown	h but not n	esulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco use contrit	pute to th	ne cause of death?
ires that the signed by the detac	3	Hypertensive A						e; 1 7	es 2 No 3	Proba	ibly 4 🗸 Unknown
of Vital Records,  og Physician: The law require.  ther this certificate has been signered director, page 2 should be	naidillo	Chronic Obstruc	ctive Pulm	onary	Diseas	. <u> </u>			psy promed? de		opsy findings available impletion of cause of 2 No
ital Relician: The sector, page		25. Was case referred to medical examiner?	Hospital: 1 / Inpatie	nt 2 🗀	ER/Outpatient		of Death (Che	eck only one)	Residence 6	Other:	
of V ng Phys After thi nneral di	- 15	1 Yes 2 No  27. Manner of Death	28a. Date of Inju (Month, Day,Y	ıry	28b. Time of Ir		y at Work?	28d. Describe	how injury occurre	ed .	disations
Division tal or Attendir rs after death. al Director: A led in by the fu		1 Natural 5 Pending 2 X Accident Investiga	fd 12-1	5-11	fd 09:0	0 am 1 Y	es 21K No				dications
Division or spital or Attending tours after death.  Increase Director: After filled in by the fune.  Contification:		3 Suicide 6 Could no determin	tbe		l:Reside	•	aliding, etc.	or Town, Dunda1	State) 6814 I k,Md.	lolal	al Route Number, City bird Ave.
Division  Division  Division  To the Hospital or Attend within 24 hours after death within 24 hours after death  To the Funeral Director; completely filled in by the			clan: To the best of mer:On the basis of exa- and manner stated.								
H S H S		29b. Signature and title of certifier		100		29c. License			29d. Date signe		
		30. Name and address of person who	o completed cause of d	leath (Item	/ (23a)	O.C.M	/I.⊏.		December		
		Russell Alexander MD.	Assistant Medic	al Exam	niner 900	W. Baltimore	Street, Bal	timore, MD 2	1223		
Stat Registra	e :	31. Date filed (Month, Day, Year) UEC 2 7 2011	2. Registra	rs signatu	park						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mattie Lee Williams 0230 AM 18 2011 December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Cit<u>v.</u> Town, or Location of Death Examiner N/A saltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 4 (North Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 217-54-3669 1 □ M 2**X** F 61 Yrs Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Baltimore Y⊓Yes 2 No N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 USA 1150 N. Longwood St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify Amer Š 3 Widowed X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Worker Elementary/Secondary (0-12) College (1-4or 5+) Case Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Mark James Williams, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1639 Lochwood Rd, Balt., MDF 21218 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any Injury or other trauonce. Marco Pearson I/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cem. 20c. Location - City or Town, State Balt., MD 20a. Method of Disposition 12/2^{Bate}/11 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funer I Servi Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): breast cancer Examiner metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed neumonia Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ungem ia 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 3 Ectopic pregnancy Day Month 5 Other (specify) 9 I Unknown 9 Unknown Williams, Mattie 23e. Did tobacco use contribute to the cause of death?

Physician/Medical þ Completed Be 27. Manner of Death

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical

Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours attended.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

State Registrar

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 Pending

investigation

1 Yes 2 No

1 Natural

3 Suicide

2 Accident

Date of Injury (Month, Day, Year)

29c. License number P24058

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

December 18, 2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

1 ☐ Yes

24a. Was an autopsy

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 X No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

2 **X**No

Year

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGEGNEHU T. GEBREYES, 900 Caton Ave, Baltimore, MD, 21229

1 

Inpatient 2 □ ER/Outpatient 3 □ DOA

28b. Time of

Injury

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MARY PATRICIA YOUSKAUSKAS 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MD N/A AGNES BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 😿 F 218-36-6578 71 Director March 5, 1940 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> Baltimore Maryland Catonsville Director 1 ☐Yes 2 No 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 5564 Channing Road 21229-1006 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2K No Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mercantile Bank Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles James Nei11 Mary Hall ၉ and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any Injury or other traum once. Norman Charles Youskauskas (Husband) 5564 Channing Rd., Baltimore, Maryland 21229-1006 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 12/29/2011 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E. Ecker 22. Name and Address of Facility Cully-Polyniak Funeral Hone, P.A. ▲ MOO175 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ACUTE MYOCARDIAL ISCHEMIA 12 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ATTHEROSCLEROSIS CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mmths? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by HYPOTHYROIDISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate Division or Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 LYCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier ** Uni M. Sheluttu M. DOO 37359 DECEMBER 26, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRIS M. SHEICITKA MD ST. A GNES HOSPITAL CENTER, 9005. CATON AVE, BACTIMORE MO

31. Data filed (Month Day, Var)

32. Data filed (Month Day, Var)

33. Data filed (Month Day, Var) 32. Preistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onna Young		1- For State Registrar	tate of Maryla		artment o ertificate o			Mental		Reg. No.	201	1 4142		
Physici Medical Exami		Decedent's Name (First, Mide     DONNA	YOU						2. Date of Domestin December		Year	3. Time of Death 2057 hrs		
		4a. Facility Name (if not instituti Prince George's Hos		mber)		4b. City, To Cheve		cation of De	ath		nty of Death e George			
Funeral Director		5. Social Security Number 216-74-3767	last birthday)	If Unde Months		If Under 24	/lin.	8irth(MM/DD/Y	(MM/DD/YYYY) 9. 8irthplace (State or Foreigly ASHING Country)					
w any		Usual Residence of Decedent 10a. State 10b. County			y, Town or Loca	ition			10d. Inside City Limits					
ryland :a-f show	Director	MD PRINC	E GEORGE'S	I	ANHAM	10f. Zip	Code			10g. Citizen o	f What Cou	1 X Yes 2 No		
with the Maryland ns 23a or 28a-f sho e notified at once.		7927 ECHOLS A	VENUE			20	706			USA				
or iten	y Funeral		farried 12. Was Dec Armed Fo 1 Yes vorced if Yes, Give Yea or Dates:	2 X No			Cuban, N	lexican, Pue	Specify Yes or I rto Rican, etc.)		Vhite, etc.	ican Indian, 8lack,		
2 hours : "natur	ted b	15. Decedent's Education (Spe Elementary/Secondary (0-12)	ecify only highest grad		16a. Deceder during m			(Give kind o O NOT use r		16b. Kind o	f 8usiness/I			
0036 within 7 giene.	Completed by	12th		,	POST	ral si			(F) - 1 M - 1 H		/ERNME	ENT		
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner	BeC	17. Father's Name (First, Middle WALTER A YOUN)	. ,					Mother's Na	me (First, Middle SMITH	e, Maiden Surna	ıme)			
MD 21 d 2 should Ith and Me n 27 is man numatic cv	ြ	19a. Informant's Name/Relation  DAMEON BARENE			1.716		(Street a	nd Number o	or Rural Route N			, Zip Code)		
		20a. Method of Disposition  1 X Burial 2 Crematio			Place of Dispos crematory or ot	sition (Nam		tery,	Date	20c. Locati	on - City or	Town, State		
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service	pecify:		ARMONY (				2/29/11			RYLAND		
Ba perm Depa Impo injur	, ,	Nachment !	N. Corns	him	7/	474 L	NDOV	ER ROA	AD HYATS	SVIILLI	E, MARY	HOME, INC.		
Physician /Medical Examiner		23a. Part II Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)				the mode of	dying, su	ch as cardia	or respiratory a	arrest, shock, or	heart	Approximate Interval 8etween Onset and Death		
ne		Sequentially list conditions,	b						· · · · · · · · · · · · · · · · · · ·					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated	C.					a						
cuted ind transit		events resulting in death) Last	Due to (or as a	·	•									
50, te be executed ysician and burial - transit	Medical	IF FEMALE:			per me,	g923	1-12-	-12 sm	Į	Load Day	a af daliusa			
Ox 687( anth certifica attending ph or use as the		FFEMALE: 23c. If yes, outcome of pregnancy 1												
hat the de ed by the letached f	by Ph	Part II. Other significant condi	tions contributing to	death but not i	resulting in the u	underlying (	ause give	n in Part I.				the cause of death?		
ds, P.C equires that een signed ould be deta				·					24a. Wa			topsy findings available		
of Vital Records, g. Physician: The law require the this certificate has been si neral director, page 2 should b	Completed	25. Was case referred to medical	al			26	S.Place of	Death (Chec	per 1 ✓ Yes	opsy formed? : 2 No	prior to death?	s 2 No		
Vita	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 l		ER/Outpatient	3 DO	A Ot	ner ₄ Nur	sing Home 5	Residence				
sion of vitending Ph death. ctor: After t	Certification:	27. Manner of Death  1 X Natural 5 Pen 2 Accident Inve	ding stigation	Day,Year)	28b. Time of I			2 No		e how injury oc				
Divis pital or At ours after d eral Direct filled in by	ertific	4 Homicide	ld not be 28e. Place (Specify)	of Injury - At h	iome, farm, stree	et, factory,	office build	ding, etc.	28f. Location or Town,		mber or Ru	ral Route Number, City		
Division To the Hospital or Attention within 24 hours after death To the Funeral Director:	Medical C		hysician: To the best miner:On the basis of and manner st	f examination a										
F > F 0	ž	29b. Signature and title of certific					License n O.C.M.				igned (Mor er 22, 20	oth, Day, Year)		
0		30. Name and address of person Donna M. Vincenti, M				W. Balti	more S	treet. Balt	imore, MD 2	21223				
St Regist	ate rar	31. Date filed (Month Day Year)		gistrar's Signat				,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Yurth Physician/ James Allen 2011 8:51 December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. 8081 Park Haven Road Dunda1k Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthdav Months Min. Hours Director 214-66-3705 1 XM 2 🗆 F 57 4/4/1954 Flordia Usual Residence of Decedent show 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f MD 1 ☐ Yes 2 🔀 No Baltimore Dundalk 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8081 Park Haven Road 21222 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō 1 Never Married 2 X Married þ filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced "natural" Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "ns any injury or other traumatic event". (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Boilermaker Industrial Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mike Yurth Ellen Snelling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason A. Yurth (Son) 8081 Park Haven Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 12/23/2011 ← □ Donation 5 □ Other (Specify) Towson, Maryland ture of Funeral Service Lice Sic Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examine Sequentially list conditions if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury Exami burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Box 68760 the as. IF FEMALE: use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the aid be detached Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No Probably 4 I Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law certificate has blirector, page 2 s autopsy perform Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes မ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA this funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending Natural work within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Accident Investigation 1 Tes 2 🗆 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State Registrar

(Check

only one

29b. Signature and title of

3

of person who completed cause of death (Item 23a) (Type, Print)

32. Registre

and

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State o	of Mary		artment of I rtificate of		d Mental Hy	giene 0		41422
	Physici		1. Decedent's Name (First, Middle, Anita Betty Z						2. Date of De Month December	17, ^{Day}	Year	3. Time of Death 1:00 p M
	/Medic Examir											
	Funeral Director		217-24-0146	.Sex 1 ☐ M 2 <b>X</b> ☐ F	7. Age (In 84	yrs. last birthday Yrs.	If Under 1 Year Months Days	If Under 24 H	lin. 8. Date of Bin (Month, Date Sept 30,			place (State or Foreign ntry) land
	yland		Usual Residence of Decedent  10a. State 10b. County			. City, Town or L	ocation					10d. Inside City Limits
	the Mar	ector	MD Anne Arun	del —————	Li	inthicum	100 71 0 4			10 000		1 ☐ Yes 2K⊠ No
	23a or	at Dir	702 Juniper Road				10f. Zip Code 21090			10g. Citizen of U.S.A.	What Cour	ntry?
920	permit. Pages 1 end 2 should be illed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 ie marked other then "naturel", or iteme 23a or 28a-f ehow eny injury or other treumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☎ Widowed 4 ☐ Divorced	12. Was Dec Armed For 1 Tyes If Yes, Gi Year or I	orces? 2 🔼 No ive	ín U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No lerto Rican, etc.)	Bl	ace - Americ ack, White, ify:White	etc.
15-0	in 72 ho n "natur	leted	15. Decedent's (Specify only highest of			16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of t	working	16b. Kind of		
212	ygiene. her ther	Comp	Elementary/Secondary (0-12)	College (	1-4or 5+)		ive Secreta	ry		Kelco Co		
land	uld be fi Aenta! H rked ot! tic ever	To Be	17. Father's Name (First, Middle, La Charles Clark Jewell	st)					^{Name (First, Middle} na Pierson	, Maiden Suma	.me)	
, Maryland 21215-0036	end 2 shores shores a selfth and Manager in 27 is mare is troums		19a. Informant's Name/Relationship Margaret Morris n	(Type, Print)					Rural Route Numb			o Code)
Baltimore,	Pages 1 ment of He ant: If iten iury or oth		20a. Method of Disposition  1 ABurial 2 Cremation 3 4 Donation 5 Other (Specific		_ !	edar Hill	Cemetery	Dec		20c. Location Brooklyn	Park,	Maryland
Ball	Depart Import eny in		21. Signature of Funeral Service Lice	A CO	1	.270	2. Name and Addre	ess of Facility Mc	Cully Polyn nue Baltimo	iak Funer	ral Hon	ne P.A.
6	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Equantially list cumulate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to	ETAS (or as a cor	sequence of):	ter the mode of dyn	ng, such as card	diac or respiratory a	rrest,	e	Approximate Interval Between
38760,	ilicate be executed physicien and is the burial-transit	dicai Exar	that initiated events resulting in death) Last	c. Due to	(or as a cor	sequence of);						
.O. Box (	iaw requires that the death certilit es been signed by the ettending f 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		oirth 2 🔲 i nant at time	Fetal death 3[	Ectopic pregnance Other (specify)	,			ate of delive	ery Day Year
ecords, P.	v requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to d	eath but not	resulting in the u	inderlying cause gr	en in Part I.	23e. Did 1	12		he cause of death?
Vital Reco	The ate h	e Completed	25 Was and referred to the first						1 ☐ Yes	psy prmed? No	Were auto prior to co death? 1 \( \sum \text{Yes}	ppsy findings available impletion of cause of 2 No
> to	hysic his ce	ToB	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆	Inpatient	2 🗌 ER/Outpatie	nt 3□ DOA OU		Death Check only	one) dence 6 🗆 Ot	ther (Specil	(y)
	Attending Profession of Attention atlon:	27. Manner of Death Natural 5 Pending 2 Accident investigati		of Injury th, Day Yea	z) 28b. Time o	Wo	yat k? Yes 2 ∐No	28d. Describe	how injury occu	irred		
DIVISION	tal or Attencrs effer death al Director:	Certification:	3 Suicide 6 Could not determine	d 286. Place	of Injury - A	At home, farm, st	reet, factory, office		28f. Location ( City or To	Street and Num wn, State)	nber or Rura	al Route Number.
	To the Hospital of within 24 hours et To the Funeral D completely filled in	Medicai	29a. Certifier TS erti yin F (Check only pre) 2 Medical Ext	amin(ar 500 rue ti	best of my asis of exar her stated	knowledge, deat nination and/or in	h conturted at the till vestigation, in my o	ns, date and pla pinion, death or	ice, and dua to the courred at the time,	cause(s) and n date and place	and due t	Nated. o the cause(s)
	To t To t	×	29b. Signature and title of certifier	J CR		(1)	29c. Licens	e number	2	29d. Date sign	-1	
	20		30. Name and address of person wh	completed cau	pl death	(Item 23a) Type.	Print)	71147	2	LA	DER J	0,201)
	Sta	te	31. Date filed (Month, Day, Year)	32.	is istrac's S	ignature.	TONTHE	pur, T	HATHOR	12, NJ	) 6	H227
	Registr		DEC 2 7	2011	enera	1. 1. 14	backs					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41423 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Shenitta D. Anderson 10: 39 AM 100 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore hospital. Agnes 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 9/05/1950 213-67-5764 Director 61 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits Director Windsor Mill Baltimore. MD 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 21244 9 Giard Drive #3 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: SpecifyAfrican-American 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) John Hopkins Hospital Administrator 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Flora Carter Dennie Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9461 Charleville #167, Beverly Hills, CA 90212 Trikeeta Anderson /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Baltimore, Maryland King Memorial Park 12/30/2011 21. Signature of Fin all Service Licenses 22. Name and Address of Facility Whie Funeral Home P.A. cf Balto. Co. 9200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ receiratory HUPOXIC failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Metastatic year Securationly fall renditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? ☐ Live Birtn ∠ ☐ 10tm = 1 ☐ Pregnant at time of death ☐ Unknown Day Month Vear 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò To the Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificate 2 1 No Yes 2 T Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1 Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗔 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MD 12.25.2011 P 25482 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h

Registrar

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31. Date filed (Month, Day, Year)

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MD 21229.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MMONS 2 AROL Medical ne (if not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Catonsville Frederick Villa Nursing Home Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month, Day, Year) 216-20-9787 **Director** 1 X M 2 D F 12-28-1925 Marvland 85 28a-f shov 10d. Inside City Limits at Oa. State 10c. City, Town or Location Director notified 1 Yes 2 XNo MD Halethorpe Baltimore 6 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral with. 21227 United States 1125 Gloria Avenue death \ 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐**X**es 2 ☐ No If Yes, Give Year or Dates. 1944 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" 3 Widowed 4 Divorced Specify: White Completed 1946 Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Schould be filed with and Mental Hygier 7 is marked other t 5+ Clergy Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ruth Amanda Brackett traumatic Hollis Andrews Ammons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other Betty J. Ammons - wife 1125 Gloria Ave., Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation Loudon Park Cem. 12-29-2011 Baltimore, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signatu eral Service an 7250 Wash Blvd., Elkridge, MD 21075 Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, leave Enter Underlying Cause (Disease or injury Examine Due to for as a consuluence of Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burial Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 No ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? certificate I 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 21 မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural work?
1 Yes 2 No 5 Pending s after death. Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) Signature

Registrar

eted cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) December 24, 2011 Physician/ 8:40 A M J. Andrews Albert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Center Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours **Director** 1**X** M 2 □ F 292-30-7705 July 11,1937 Ohio Yrs 74 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a. State Director 1 Yes 2 XNo Dundalk Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Apt 4 2031 Bear Ridge Road 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 XMarried 'natural", or þ 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the B & O Railroad Field Engineer 12 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or مثلاً Reese Andrews Gladys Perdue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Andrews wife 2031 Bear Ridge Road, Apt 4, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 Burial 2X Cremation 3 Removal from State Bayview Crematory 26, 2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Signatore of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician/ Dewenten 2 heimel yours disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that the dearh certificate be executed Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Box 68760 a endigp IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal God. ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed? has page 2 this certificate Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) WSL PLC 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: To the Hospital or Attending Natural 2 Accider 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the f after death Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning and the state of examiners and the state of examiners are stated. Medical 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number NV December 24 2011 8303 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W 6701 50 Tonson MM WANGS Churcy N.

State Registrar 28

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 06;22A M STON Dec 2011 ALVIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town or Location of Death Examiner BAHO CTY

If Under 1 Year If Under 24 Hrs. HOSPITAL OF BAITIMORE 8. Date of Birth (Month, Day, 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-50-238 Months Days Hours Min. Country) Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show the Medical Examiner must be notified at 1 Yes 2 No Director BALTIMOre 28a-f 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 0. death with 21215 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 b 1 □Yes 2 ☑ No Specify If Yes, Give Year or Dates à BIACK 3 ☐ Widowed 4 ☐ Divorced 'naturaf", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other tra Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE eeding 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KEARNEY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) APT 422 BAHOND, 21215 PARKHEIGHTS AVE. STOM GERALdine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Mac Cremation 3 ☐ Removal from State CATONSVIILE, Md. METro 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility
Michael 7:glier Funeral Suc. P.A.
3512 Frederick Ave BAHO, Mb 21229 21. Signature of Funeral Service ! 23a, Part 1. Enter the disease, a constitutions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Be Completed by Physician/Medical phy: 88.1 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No 24a. Was an page 2 s has autopsy performed? Yes 2 Nio certificate 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 To the Hospital or Attending (Month, Day, Year) 1 Natural 2 Accident 5 ☐ Pending investigation Injury after death. М 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide within 24 hours a 29a. Certifier tx certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner-stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of RES-000 person who completed cause of death (Item 23a) (Type, Print) Hospital 1 thmore, MD Sinae 31. Date filed (Month, Day,

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Peret Fulf (22) and 30 2012 nettle of Health and Mental Hygiene 41427 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Ethel Burns 2:40 **A**M 12/21 /2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Gilchrist Hospice Columbia 439-86-1652 439-86-1652 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months Hours Director 1 □ M 2 🔏 F T.A 4/5/1917 94 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director MD Howard Columbia 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o Examiner must be 23a Funeral 7070 Cradlerock Way, Apt. 120 21045 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 0 1 X Never Married 2 Married ò ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify:Black "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Retail** the Clerk other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Geneva Rohilliard Steve Burns II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 James Burns Jr./Son 11805 Gaslight Place, Columbia, MD 21044 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Baton Rouge, LA 12-30-2011 Roselawn Cemeterv 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Rd., Inc. Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MUDEARDIAL INFARCTION DAYS disease or condition Medical resulting in death) Examiner UFARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death the hed 9 Unknown P.O. signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death?

1 Yes 2 No has certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Normal Other (Specify,} \) 2 🔀 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After to completely filled in by the funer 1 X Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 06 4395 29d. Date signed (Month, Day, Year) DECEMBER 21,2611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA, MD 21044 6336 CEDAR LANE

Registrar DHMH 17 Rev 06-2011

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32. Registrar's gnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec. Day 2011 Year Physician/ 9:33 AM 21 Robin Ann Hartlove Berg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** Months Hours (Month, Day, Year) **Director** 213-84-7454 1 M 2 X F Yrs July 5, 1964 Maryland 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified York PA York 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 17402 2601 Chronister Farm Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: White Completed 3 Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Il Hygiene. Elementary/Secondary (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic even h and Mental H 7 is marked of မ Mary Ann Bolla Bernard Edward Hartlove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6617 Commodore Court, New Market, Maryland 21774 Melodie A. White - Friend 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State E1Kton Run Cemetery 12/29/2011 Elkton, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP MO1283 7250 Washington Blvd., Elkridge, Maryland 21075 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line shock, or heart failure. Lis Interval Between Immediate Cause (Final set and Death Physician/ PROCEPATIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): g physician and as the burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 / the attending phorhed for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mog Year Month Day Pregnant at time of death 1 ☐ Yes ∠ □ g ☐ Unknown g | Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABOTOS MOLL Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autonsy r this certificate has eral director, page 2 death? 2 TNo Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 Tes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral c 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 \( \sum \) Yes 2 \( \sum \) No 5 Pending iniury Natural 2 Accident Investigation Funeral Director: Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

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State Registrar 31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type,

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KROW MI

DHMH 17 Rev 1/2001

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 41430 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:50 AM 2011 December Medical Robert Lewis Borngesser 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown <u>18910 Monticello Drive</u> If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 578-40-3646 Months Days Hours Min Director 79 1 🛛 M 2 🗆 F April 3, 1932 MMissouri 28a-f show ms 23a or 28a-f sho must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18910 Monticello Dr. 21742 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?
1 X Yes 2 \sum No 1951-Black, White, etc. 5 1 Never Married 2 X Married Completed by Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: white "natural", 3 Widowed 4 Divorced 1955 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) journalist journalism Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important; if Item 27 is marked any Injury or other traummingones. ည Andrew George Borngesser Nelle Coy Keene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Price - wife 18910 Monticello Dr; Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Ther (Specify) 22. Name and Address of Facility State Anatomy Board e of Funeral Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Dav Year 4 Pregnant at time of death 9 Unknown signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death?
1 Yes 2 No performe certificate Yes 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of ex nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29d, Date signed (Month, Day, Year, ompleted cause of death (Item 23a) (Type, Print) LASSII 31. Date filed (Month, Day, State 2 8 21742 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 41431 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 26 Isabella Oppel Burkhardt 2011 December 7:00 рΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9534 Many Mile Mews Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months (Month. Day, Year) Director 026-18-0432 1 M 2 X F 94 04/20/1917 Usual Residence of Dec NY 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD Howard Columbia 1 Yes 2 X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 9534 Many Mile Mews 21046 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? 0. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry ygiene. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Physical Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, marked ည George Oppel Ida May Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Susan Johnson - Daughter Columbia, MD 9534 Many Mile Mews 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 permit. Page 1 Department of I Important: If it any injury or o ☐ Burial 2 Cremation 3 ☐ Removal from State 12/27/2011 Ardent Crematory 4 Donation 5 Other (Specify) Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death

MONTHS > YEAKS Immediate Cause (Final disease or condition Physician/ DYSPHAGIA Medical resulting in death) Due to (or as a consequence of): Examiner YEARS DEMENTIA Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transi Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DEBILL TY Records, 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 24 hours after death.

Funeral Director: After 28d Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Division Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by the Hospital 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0069962 Ali Wary, 12/27/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6334 CEDAR LANE, LORIEN COLUMBIA, MD, 21044 State Registrar

Please Type or Print in Black Indelible Ink English All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 For State Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) John Stephan Bilobran 2 Date of Death 3. Time of Death Month Physician/ 718A December 2011 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Dalhmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Sex 7. Ade (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours Min **Director** 386-46-0613 1**X**] M 2 □ F Yrs 65 04-08-1946 Ohio Usual Residence of Decede 28a-f show death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2X No NC Wilmington New Hanover 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 6605 Providence Road 28411 United States items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

X Yes 2 No Black, White, etc. ō 1 Never Married 2 X Married þ Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Auditor Veterans Administration 5+ and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Bilobran Tessie Fraund 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. 6605 Providence Road Wilmington, NC 28411 Jacqueline A. Bilobran / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Odenton, Maryland Arundel Crematory | 12-21-2011 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. Annapolis Road Odenton, to 1. ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ook, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Airway Obsi Obstruction Ph sician/ disease or condition Medical resulting in death) Examiner unsy concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (o a a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and for use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 2 No 1 Yes 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 cember 1011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhmore MD Wolfe St. Heitham 31. Date filed (Month, Pay, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 20 41433 Certificate of Death 1. Decedent's Name (First, Middle, Last)
SHIRLEY 2. Date of Death 3. Time of Death BALTHO Physician/ 7:09 P M December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours **Director** 234-58-6360 1 □ M 2 🔀 F June 14, 1938 West Virginia 73 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe r items 23a o Funeral 2012 Cherry Road 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status of Health and Mental Hygiene. item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 11/88/6/ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) P Andy Howard Nutter Maggie Udora Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2012 Cherry Road, Edgewood, Maryland 21040 permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Alex Baliko III, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Harman Funeral Services 12-26-11 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part f. Enter the discase, or complications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on cach line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cance disease or condition resulting in death) Medical Due to (or as a cond quence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Attending Physician: The law requires Records, 1 Z Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0663220 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

016932

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 23, 2011 11:30 AM Vera Theresa Britton Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Earleville 36 Kent Ave. 8. Date of Birth (Month, Day, OCt. 11 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Year) 1 □ M 2🏋 F Months Mary land Director 1942 218-40-0315 69 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Tes 2 No Maryland | Earleville Cecil 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21919 36 Kent Ave. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏞 No Specify: If Yes, Give Year or Dates Specify: White Completed 3₺ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 73 Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Health Care Registrar permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Wilhelm Schrobsdorff Ella Martha Dabruck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3733 Miller Road, Street, Maryland 21154 19a. Informant's Name/Relationship (Type, Print) Richard T. Greezicki / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Remove 4 Donation 5 Othe (Specify) Air Memorial Gdn 12-27-2011 Bel Air, Maryland 21. Signature of Funeral 22. Name and Address of Facility McComas Funeral Home, P.A. West Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Inset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year Pregnant at time of death signed by the a ld be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been sis completed filled in by the funeral director, page 2 should be Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed7 Yes 2 No death? 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗷 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of Pertifier 29c. License number 20023322 12.27.2011 achdow & Mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day,

Elkan MD 21921

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 21, 2011 3:10 A.M Judith Κ. Blische Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 217-38-4339 1 🗆 M 2 💢 F 70 July26,1941 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Funeral Director Md. Baltimore Millers Island 1 🗆 Yes 2 🖔 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 9016 Hinton Avenue U.S.A. 21219-1657 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2※☐ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc P þ 1 Never Married 2 Married Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 XNo Specify Specify: White "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Mercy Elementary/Secondary (0-12) College (1-4 or 5+) Medical Center 12th Secretary Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Tellis Raymond Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Lawrence O'Donnell 9016 Hinton Avenue Baltimore, Maryland21219 DECEMBER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 27,2011 Baltimore, Maryland M00933 22. Name and Address of FacilitKaczorowski Funeral Home, P.A. Signature of Funeral Service Licensee Robert J. Godack, 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Ph, sician THYROID CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any reaching to increalist cause. Enter Underlying Examine Due to for as a consequence of attending physician and I for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 Probably 4 Unknown JUDITH Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 TO Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 5 Pending 1 X Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of

JACKIE JONES,

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

CRNP

28

0

TIMONIUM, MD 21093

Registrar

State

31. Date filed (Month, Day,

Year)

28

11-09522	
Duran Brooks	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ouran Brooks		State of Maryland / De 1- For State Registrar	partment of Ce <i>rtificate of</i>		and Ment	al Hyg		1. No. 21	0 1	1 4143	
Physicia Medical Examin	n/	Decedent's Name (First, Middle,Last)					Date of Death Month	Day Year		3. Time of Death 0010 hrs	
Medical Examin	eı	Duran R. Brooks  4a. Facility Name (if not institution, give street and number)	4	b. City. Town.	or Location o		December	19, 2011 4c. County of	Death	00 10 hrs	
		Johns Hopkins Hospital - NCCU		Baltimore				N/A			
Funeral	╗	5. Social Security Number 6. Sex 7. Age (In yr	s. last birthday)	If Under 1 Y			B. Date of Birth	(MM/DD/YYYY)	9. Birth		
Director		214-64-1169 1XM 2_F	57 Yrs.	Months D	ays Hours	Min.	09/26		Cou	ntry) MD	
any		Usual Residence of Decedent  10a. State 10b. County 10c. C	City, Town or Location	on					$\neg$	10d. Inside City Limits	
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5-00; ed with lygiene lygiene the Mee	Ĕ	8th Grade  17. Father's Name (First, Middle, Last)	Busir	ness C		s Name (Fi	rst. Middle. Ma	Self			
21; be fill rked ent,	B	Melvin			Mary	Eli	zabet	h Brook			
	٩	19a. Informant's Name/Relationship (Type, Print) Shenika Brooks (daughter)						er, City or Town, timore,		Zip Code) D 21214	
4 E E E	I	20a. Method of Disposition 20 Removal from State	b. Place of Disposition of the crematory or oth		cemetery,	D	ate	20c. Location - C	ity or T	own, State	
Baltimore, permit. Pages I a Department of He important: If ite		4 Donation 5 Other Specify:	on-site		tory	12/2	6/11	Baltimo	re	, MD	
Baltimore permit. Pages 1 Department of F Important: If i		21. Signature of Funeral Service License	²² J\ ²	rsephar 10 N.	en of Fagility Fulto	own n Av	Jr. F	uneral altimor	Ho	me PA MD21217	
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A Andrews	1	or condition resulting in death)  Due to (or as a consequence beguentially list conditions,	e of):								
	힐	if any, leading to immediate cause. Enter Underlying Cause	e of):								
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ox 6876 ath certificat attending ph	Physician/M	past 12 months?	f death - H	al death er (Specify)	3Ectopic	pregnancy		Month	Da	ay Year	
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res that the signed by	S P	Part II. Other significant conditions contributing to death but no			e given in Par	t I.				ne cause of death?	
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COF	Completed	-				_	autopsy	prio		impletion of cause of	
tal Rection: The Certificate ector, page		25. Was case referred to medical		26 DI	ace of Death (	Check only	1 ✓ Yes 2	No1 <u></u>	Yes	2 No	
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ision of Vital   Attending Physician: Actent. Acter After this certif by the funeral director,	- 1	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of In	· ·   _	njury at Work?	28	d. Describe ho	w injury occurred			
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Division of Vital Records, ospital or Attending Physician: The law requirement after death.  Internal Director: After this certificate has been siy filled in by the funeral director, page 2 should be after the second or after the second or after the second or after the second or after the funeral director, page 2 should be after the funeral director, page 2 should be after the funeral director, page 2 should be after the funeral director.	Certification;	3 Suicide 6 Could not be determined (Specify) Res	it home, farm, street sidence	t, factory, offic	e building, etc		f. Location (Str or Town, Sta altimo:	ite) 236 S.	or Rura <b>Spr</b>	ing Ct.	
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To wit To con	Me	29b. Signature and title of certifier			ense number			29d. Date signed			
		Cariol Hallan		0.0	C.M.E.			December 1	9, 20	11	
8		30. Name and address of person who completed cause of death (It Carol Allan, MD Assistant Medical Examiner	,	more Stree	et, Baltimo	re, MD 2	21223				
Sta		31. Date filed (Month_Day Year) 32. Redistrar's Sign		Nes!							
Registra	ar	DEC 28 2011 Seme	P. 196	1							

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		•	For State Registrar				tificate of			Reg. No. 2	011	4 4	<u> 38</u>
	Physicia Medic		1. Decedent's Name (First, Middle, Mary Ann Colli	er					2. Date of Death  Month Day Year  7  9  9				
ا المحسيد	Examin		4a. Facility Name (if not institution, 45 W. Baltimor	e St., Apt.		H	Hag	erstown		4c. County of Death Washington			
1	Funeral Director		5. Social Security Number 219-50-0829 Usual Residence of Decedent	6. Sex 1 M 2 X F 7. Ag	je (In yrs. Ia 63	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da 8/21/19		9, Birth Coui	place (State or Fo htry) SC	oreign
	and show lat	ō	10a. State 10b. County		10c. City	, Town or Lo	cation	-				10d. Inside City L	.imits
	Maryla 28a-f otified	Director	Maryland Wash:	ington		Hage	rstown					1 🛚 Yes 2	□No
	s 23a or sust be n	Funeral D	10e. Street and Number 45 W. Baltimor	e St., Apt.	421		10f. Zip Code 21	740		10g. Citizen of -blac		usa	
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The marked of the tran "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show items 27 in a continue and 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items 25a or 28a-f show items	δ	11. Marital Status  1 ☐ Never Married 2X Marr  3 ☐ Widowed 4 ☐ Divorced	ied  12. Was Decedent Armed Forces?  1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	Ever in U.S No		Was Decedent of I If Yes, specify Cub 1 □ Yes 2 🕅 No	dispanic Origin? (Span, Mexican, Puerton Specify:	pecify Yes or No- o Rican, etc.)		ce - Ameri ack, White, y: <b>Afric</b>		an
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lary	should and M is ma		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Street	Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
e,	and 2: Health :em 27 ther tr		Toi Collier / Dang 20a, Method of Disposition	hter	20h Bi		Newcastle	Road, Balt	imore, Mar	ryland 21		our State	
nor	e i i i		1 X Burial 2 ☐ Cremation 4 ☐ Donation / □ Other (S	3 🗀 Removal from State	, Ce	emetery, crer	natory or other pla Cemetery		0/2011		•		
altir	permit. Par Departmer Important any injury once.		21. Signature of Funeral Legicle (S		ML	22	2. Name and Addre	ess of Facility	ylie Fune	Baltimo ral Home	P.A. o	fBalto. Co	J.
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← F	Ph _{sician/} Medical Examiner	17	23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	or respiratory ar	rrest,		Approximate Interval Betwee Onset and Dea						
		ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequ	ence of):							
	be executed sician and burial-transit	cal Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):							
376(	ficate g phys as the	Medi	15.55.44.5	d									
. Box 68760	To the hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No g ☐ Unknown	1 Live Birth	If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) g ☐ Unknown					23d. Date of de Month		very Day Year	r
P.O.	that the ined by e detail	by Pł	Part II. Other significant condition	ns contributing to death I	out not resu	ulting in the u	underlying cause g	iven in Part I.	23e. Did 1	tobacco use cor	ntribute to	he cause of deat	.h?
rds,	equires sen sig ould b	ted	15/0	betes					10			bably 4 🔲 Unl	
ecol	has be	Completed	- H	Abéntenzia		\	24.		24a. Was auto perf			opsy findings avai ompletion of caus	
E E	ilcian; The la certificate ha rector, page		25. Was case referred to medical	NISHEROLL.	Naza	1/am	Diseas	Place of Death (Che	1 🗆 Yes	2 No	1 Tyes	2 No	
Vit ₂	ysicia nis cer direct	To Be	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpat	ient 2 🗌 I	ER/Outpatier		ner	lome 5 Resi	idence 6 🗌 Ot	her (Specit	y)	
υot	ling Pt n. ∆fter th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin			28b. Time of injury	wor	k?	28d. Describe	how injury occu	rred		
Division of Vital Records,	or Attendafter death Director: / in by the i	Certificate:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	not be			M 1 L	Yes 2 No	28f. Location ( City or To		ber or Rura	al Route Number,	
	to the hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of Nurse Practioner: To the	examination	and/or invest	tigation, in my opin	ion, death occurred	at the time, date	and place, and d	lue to the c	ause(s) and manne	er stated.
	To the Comp.	4	29b. Signature and little of certifier				29c. Licens			29d. Date sign		Day, Year)	
	1		30. Name and address of person v	who completed cause of c	death (Item	23a) (Type, F		1				+	
	Sta	0	31. Date filed (Month, Day, Year)	32. R 41st	ar's Signati	INUT	17 H	ogerstu	IN WY	717	40		
	Registra		DEC 2	8 2011	24.4	1 1	alle						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $P^{\,\mathsf{M}}$ 8:59 William December 2011 Watts Clendaniel, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore 114 Rosewood Avenue Catonsville Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day, 1 🖾 M 2 🗆 F Hours Min **Director** 215-32-4518 77 Maryland Usual Residence of Decedent 10a State Page 1 and 2 should be filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗷 No Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 114 Rosewood Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. Postmaster U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William W. Clendaniel, Sr. Margaret Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blaine P. Clendaniel Wife 114 Rosewood Avenue; Catonsville, MD 21228 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date i o 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Atlantic Crematory 12-21-2011 Glen Burnie, Maryland 22. Name and Address of Facility Sterling Ashton Schwah Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Sign, ure neral Service Licensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph sician/ Meelne Medical Examiner Sequentially list conditions if any leasting to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami attending physician and for use as the burial-transit Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Live Tetal do... signed by the atte in the past 12 months?
1 ☐ Yes 2 ☐ No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ျင 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie DAMBAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BURCHESS Oal) State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ REMINS Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner Howard Ellicott City Ellicott City Nursing & Rehab 9. Birthplace (State or Foreign Country) Fingland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 6. Sex Funeral (Month, Day, Year) Months Days Hours 1 □ M 2**Y**□ F 90 Director 126-30-7892 1111 v Usual Residence of Deceden Show 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 72 hours after death with the Maryland Director 1 🗆 Yes 2 🖵 No Elkridge Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA Elkridge 8100 Arbor View Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 📆 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White 3 XWidowed 4 ☐ Divorced "natural", Year or Dates. event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) than, permit. Page 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Supermarket Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Helen Naylor Arthur Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Cremins - Son 8100 Arbor View Way, Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/20/2011 Media, PA Media Cemetery 22. Name and Address of Facility Gary L. Kaufman Funeral Home Funeral Servic 21. Sign 7250 Washington Blvd., Elkridge, MD 21075 M01283 @ MMP. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hiy one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List of Approximate Interval Between Onset and Death Immediate Cause (Fina STROKE Pnysician/ disease or condition Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine and -transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical P.O. Box 68760 the attending pt thed for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mont Year Month Day Pregnant at time of death 2 1 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has page 2 2 1 No 2 1 No 1 🗌 Yes Yes 25. Was case referred to project funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tyes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Funeral Director; After completed filled in by the funer Natural
Accident work? injury 5 Pending death. М Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined hours after City or Town, State) within 24 hours a To the Hospital Medical Ϊ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEANSTH MID. 21 State

Registrar

11-09502 - Ellis David Clayto	or, l	Please Type of State of	r Print in Bla of Maryland /						egible	201	4 4 4
		I- For State Registrar		Certifi	cate of D	eath			Reg. No.		
Physicia Medical Exami		Decedent's Name (First, Middle,Last)     ELLIS DAVID CLAYT	OR, III					2. Date of Do Month Decemb	er 18, 2	Year 2011	3. Time of Death 0620 hrs
		4a. Facility Name (if not institution, give 5237 Marlboro Pike #304	street and number)			City, Town, o Capital Hei	r Location of De ghts, MD	ath	- 1	: County of Death Prince George	s
Funeral Director		5. Social Security Number 6. Sex 579-74-1760		(In yrs. last b		f Under 1 Yes Months Day		8. Date of 07/0	•	DD/YYYY) 9. Birth Foreign Cou	Nashington DC
nd show any	Į	Usual Residence of Decedent  10a. State 10b. County  MD PG	1		on or Location pital H	 Ieights	5			I	10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 5237 Marlboro Pik	e #304		10	Of. Zip Code 2074	13		10g. Citi	zen of What Count	try?
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married		ver in U.S.	If Yes,		n, Mexican, Pue	(Specify Yes or I arto Rican, etc.)		14. Race - Americ White, etc.	
urs afte tural",	à	3 Widowed 4 Divorced  15. Decedent's Education (Specify onl	or Dates:	leted) 16a	a. Decedent's l	Jsual Occupa	ation (Give kind			Kind of Business/In	
D36 thin 72 hounde. references	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+	-)		of working life Intant	e. DO NOT use	retired)	L	Priva	ate
15-0036 filed within 7 Hygiene. d other than		17. Father's Name (First, Middle, Last)					_	ame (First, Middle Dale			· ·
2121 ould be fi marked ic event,	To Be	Ellis David Clay  19a. Informant's Name/Relationship (Ty	<u> </u>	- 11	19b. Mailing Ad	dress (Stre		lie <del>Del</del> or Rural Route N		rtin ity or Town, State,	Zip Code)
MD d 2 sho lth and n 27 is		Danita L. Claytor	-Daughter								MD 20743
more, Pages I an nent of Hea ant: If iter		20a. Method of Disposition  1 Burial 2 X Cremation 3 4 Donation 5 Other Specify:		crem	e of Disposition latory or other p apeake	_{place)} C <b>rema</b> t	cory 12		1 Be	Location - City or T	, MD
Balti Permit. Departm Imports injury o		21. Signature of Funeral Service Licens	ee N / N							al Service, MD 2074	
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Examiner		Immediate Cause (Final disease a. ]	Hypertensi		nerosc1	erotic	Cardio	vascula	r Dis	sease	Death
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760, icate be physic the bur	an/Medic	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome		Су			ananov	23	d. Date of delivery  Month D	ay Year
Box 68760, e death certificate be exthe attending physician ed for use as the burial	Physiciar	past 12 months?  1 Yes 2 No 9 Unknown	Pregnant at ti	me of death	2 Fetal of 5 Other	(Specify)					Ŋ
s, P.O. ires that the signed by t	Š	Part II. Other significant conditions Diabetes, Obesit		but not result	ing in the unde	erlying cause	given in Part I.			No 3 Prob	the cause of death? ably 4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Completed							pe	as an topsy rformed? s 2 \ \	prior to death?	opsy findings available ompletion of cause of S
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		4 M.	1/			O.C	.M.E.		Dec	cember 18, 20	011
1/1		30. Name and address of person who so Jack Titus MD. Deputy C	mpleted cause of de Chief Medical Ex			timore Str	eet, Baltimo	ore, MD 2122	23		
		31. Date filed (Month, Day, Year)	32. Registrar								
Reaist	rar	DEC 2.8 2011 /2	MARKAN 10.	No. of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of Contract of							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41442 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2011Month Physician/ :15P Dec.16 Inez Curtis Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Summitt Nursing Home Baltimore 5. Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthpia. Country) MD **Funeral** 1 □ M 2 🔀 F Months Days Hours (Month, Day, Ye **Director** 214-24-9061 89 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Funeral Director Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1808 N. Dukeland Street 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes XXNo
If Yes, Give
Year or Dates. Black, White, etcAfrican 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: American 3 ₺ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Hutzler's Retail Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Matthews George Brown Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216Delroy Curtis-Son N. Dukeland Street Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Baltimore Nat 1 XX Burial 2 Cremation 3 Removal from State 12-23-11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Liegnsee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Štreet Baltimore, MD 21217 23et. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List provide on each line. Onset and Death Immediate Cause (Final SACRAL DECUBITUS ULCER INFECTED Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed CEREBROVASCULAR ACLIDENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 12-19-11 MO

DHMH 17 Rev 7/2009

State

Registrar

HAMMONDS

FERRY RD

BALTIMORE, MD 21227

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

AWAR

Date filed (Month, Day, Year)

DEC 2 2 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 41443 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 19, 2011 10:40 A M John Austin Collard, Jr. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 2703 Oak Leaf Court Odenton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) Country) **Director** 401-26-3526 1 **X** M 2 □ F Yrs 89 11-13-1922 Tennessee Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Anne Arundel Odenton 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n within 72 hours after death with United States 21113 2703 Oak Leaf Court items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Examiner Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 nan "natural", e Medical Exam 1 ☐ Yes 2 🛛 No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than State of Maryland Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Higher Education Administrator marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ulth and Mental H ပ John Austin Collard, Sr. Timmie Sermon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 2703 Oak Leaf Court Odenton, Maryland 21113 Nancy R. Collard / Wife 20b. Place of Disposition (Name of cemetery, crematory or other plantion National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of 1
Important: If it
any injury or of ď 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-15-2012 Arlington, Virginia Funeral Sen 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 411 Annapolis Road Odenton, Maryland 21113 Approximate Interval Retween Onset and Death disease Immediate Cause (Final Phylician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ξ Month Day the □ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure to thrive Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performe Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Director: After Natural 5 Pending death. 1 Yes 2 No 2 \( \subseteq \text{ Accident} \) Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) M686053 122011

Registrar

DHMH 17 Rev 06-201:

State

MD 21146

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

213 Newport Drive Severna Park

213 New port
31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 7:04 P M December Catherine Shirley Correll Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Bel Air Harford 128 West Ring Factory Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1 M 2 XF Months Days Hours Min. Pennsylvania 162-20-3193 Yrs 1927 Director 84 Apr. Usual Residence of Decedent or 28a-f show e notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🖁 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be Funeral 128 West Ring Factory Road 21014 USA ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. "natural" Completed 3 X Widowed 4 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. n and Mental I မ Mary Elizabeth Thompson Caspar Cook McCune 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\underline{MD}$ Terry J. Correll 1226 Graystone Road, Bel Air, 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Hilltop Service Corp 12-30-2011 Towson, Maryland 21. Signatur Funeral Service Lige 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ CHIRDNIC OBSTRUCTIVE PULMONARY DISEAS ) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No ģ Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA uter death.

**I Director: After the still by the fure.** 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) E 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL AIR MB 21014 NORTH

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) - - - -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician/	1- For State Registrar	Certificate o	f Health and Mental H f Death	ygierie Reg. N	. 201	14144
dical Examine	Decedent's Name (First, Middle,Last)     Lisa Collins			Date of Death     Month Day     December 21	v Year	3. Time of Deeth 2028 hrs
	4a. Facility Name (if not institution, give street a		4b. City, Town, or Location of Death		4c. County of Death	
Funeral	Baltimore Washington Medical C  5. Social Security Number 6. Sex	7. Age (In yrs, last birthday)	Glen Burnie  If Under 1 Year   If Under 24Hrs	8. Date of Birth (M	Anne Arundel  M/DD/YYYY) 9. Birth	nplace (State or
Director	568-13-2924 1 M 2		Months Days Hours Min		Foreign	
Any .	10a. State 10b. County	10c. City, Town or Locar	tion			10d. Inside City Limits
Aaryland 28a-f show 1 at nace. ector	Maryland Anne Arunde	l Co. Glen Bur				1 Yes 2XX No
th the Maryland 23a nr 28a-f sho notified at nnce. al Director	10e. Street and Number 7880 Tall Pines Co	irt. Apt. G	10f. Zip Code 21061	1 *	Citizen of What Coun United Sta	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director	11. Marital Status 12. Wa	s Decedent Ever in U.S. 13. Wated Forces? If N	as Decedent of Hispanic Origin? (Sp /es, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ	
frer dez Fr. mr i er mu	3 Widowed 4 Divorced If Yes, Gi	Yes 2 X No	Yes 2 No specify:		Specify: Wh:	ite
natural"  xamine	15. Decedent's Education (Specify only higher	st grade completed) 16a. Deceder	nt's Usual Occupation (Give kind of v		. Kind of Business/Ir	
5-0036 ed within 72 hour tygiene. inther than "natu the Medical Exar Completed	Elementary/Secondary (0-12) Collinary 12 yrs.	ege (1-4 or 5+)	Lebotomist	·	Health Car	re
21215-0036 uld be filed within 7 Mental Hygiene. marked uther than c event, the Medica To Be Comple	17. Father's Name (First, Middle, Last)			(First, Middle, Maid		
1715-0036 Id be filed within 72 hours fental Hygiene. starked ather than "naturevent, the Medical Exam Be Completed to	John Blisard  19a. Informant's Name/Relationship (Type, Prin	Local Market	Chery1			
Baltimore, MD 21215-00: permit. Pages 1 and 2 bould be filed with Department of Health and Mental Hygiere Important: If item 27 is marked wher t injury or other transmatic event, the Med	Mr. David C. Collins,		g Address (Street and Number or F 30 Tall Pines Cou	Rural Route Number, Int. Apt.	City or Town, State, G Glen Bi	Zip Code) 21061 urnie, MD
re, R 11 and 17 Health 17 item er fran	20a. Method of Disposition  1 Burial 2 X Cremation 3 Remo	20b. Place of Dispos	sition (Name of cemetery,		c. Location - City or	
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other ti	4 Donation 5 Other Specify:	Atlantic	Crematory 12/	27/2011	Glen Burni	le, MD
Dalt permit. Departs Import injury	21. Signature of Euneral Service Licensee		Name and Address of Facility Sin			
Physician	23a. Part I. Enter the disease, or complications failure. List only one cause on each line.		rvices PA; 1 2nd	AVE SW; C	hock, or heart	Approximate Interval
/Medical		enhydramine,Mepro		е, охушогри	ione,	Between Onset and Death
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (c.		28a-f,per me,g92	3 1-31-12	Sm	
J. BOX 68/61 t the death certificate by the attending phy sched for use as the t Physician/M	past 12 months?	Prognant at time of dooth	etal death 3 Ectopic pregna		23d. Date of delivery Month D	ay Year
at the d by the grached		ting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
S, P.C. uires that n signed ld be dea				1 Yes 2	No 3 Proba	ably 4 🗸 Unknown
Kecords,  The law require ficate has been sig page 2 should be				24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
cian: The certificate ector, page	25. Was case referred to medical examiner?		26.Place of Death (Check		No 1 Yes	s 2 No
Physician Physician er this certi ral director	1 ✓ Yes 2 No				dence 6 Other:	
on of or of or of or of or or or or or or or or or or or or or	1 Natural 5 Pending	Date of Injury Month, Day, Year)  1 12-20-11		28d. Describe how i	njury occurred	
DIVISION OF VITALING TO THE HOSPITALING AND TO THE HOSPITALING AND THE HOSPITALING AND THE COMPLETE AND THE THE COMPLETE AND THE THE THE THE COMPLETE AND THE THE THE THE THE THE THE THE THE THE	Accident Investigation  3 Suicide 6 Could not be determined	Place of Injury - At home, farm, stre	<b>3 .22</b>	28f. Location (Stree or Town, State)	t and Number of Run 7880 Tall	al Route Number, City Pines Ct.
Hospit 24 hour Functri ely fill	29a. Certifier (Check only 1 Certifying Physician: To the	e best of my knowledge, death occu lasis of examination and/or investiga			and manner as state	
i Parti	and mar	iner stated.	29c License number		d. Date signed (Mon	
To the Ho within 24 P. To the Fur completely	29b. Signature and title of certifier	- / /			-	
To the within 2 To the complet	liell 10	Course of death (MS 22-)	O.C.M.E.	Do	ecember 25, 20 	11
To the within 2 To the complet	30. Name and address of person who completed	Cause of death (Item 23a) edical Examiner 900 W. E			ecember 25, 20 	11
To the complete Complete Registrar	30. Name and address of person who compréted Zabiullah Ali, M.D. Assistant M				ecember 25, 20	11

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Month 12/24/2011 Day Physician/ 10:30 AM Regina Elizabeth DePiano Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1707 Wycliffe Avenue Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
MD 1 🗆 M 2 🗓 F (Month, Day, 7/10/1934 375-32-2586 **Director** Usual Residence of Deceden 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Director 1X Yes 2 ☐ No Baltimore MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 USA 1707 Wycliffe Avenue death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. ☐ Yes 2 X No Baltimore, Maryland 21215-0036 SpecifyAfrican-American 1 ☐ Yes 2X No Specify. Completed 3 🗌 Widowed 4 💢 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City School School Health Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Essie Price Howard Faulcaun, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3111 Weaver Avenue Baltimore, Mary Land 21214 Collynn R. Riggs / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/31/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) King Memorial Park 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road Randallstown, Maryland 21133 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ance month MIL Due to (or as a prinsequence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and is the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L Fetal Geath 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No Osteonorosis 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

1 X Natural

2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one address of person who completed cause of death (Item 23a) (Type, Print) 30. Name ang

State Registrar 32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 25 Year 2011 Physician/ Rosemary owne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Howard County General Hospital If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** (Month, Day, Year) 023-42-9248 **Director** 1 □ M 2 🗓 F Yrs Massachusetts 60 11-30-1951 Usual Residence of Dece 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director an "natural", or items 23a or 28a-f s Medical Examiner must be notified Columbia 1 Yes 2 X No Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 U.S.A. 5138 Homecoming Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lih and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the Zimmeman Associates Data Analyist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Hazel O'Neil James Crosson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) erritt. Page 1 and 2 shepartment of Health at portant: If item 27 is Columbia, MD 21044 5138 Homecoming Lane Thomas Downey (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Atlantic Crematory 12-31-2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) er mit. Signature of Funeral Service Lidenses 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road Columbia, MD 21045 mr or K. Muc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami burial-transit Due to (or as a consequence of): resulting in death) Last ding physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No should be detached for Year Month Day Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 
Yes 28b. Time of Certificate: Natural 5 Pending 2 🗌 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 🗆 Certifying Nyse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 264870 Dec 26 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year MARGALET £ 0725 4 M 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death Columbia Howard Howard County General Hospital Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 215-50-7229 **Director** 1 □ M 2 🔏 F England 88 March 24, 1923 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Howard G1enwood 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be with Funeral 21738 U.S.A. 3191 Sharp Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 😿 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural". Specify: White 3 X Widowed 4 Divorced Completed other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Baby-Sitter Self Employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file h and Mental F 7 is marked o မှ Joseph Saunder Lillie Pache 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health al Important: If item 27 is any injury or other trau 3191 Sharp Road Glenwood, Maryland 21738 Valerie Schwaner (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Dean Mountain Cemetery 12-20-2011 Elkton, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. Signatura 5555 Twin Knolls Road Columbia, Maryland 21045 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ CAADIA WHEN disease or condition Medical resulting in death) Examiner ATHELD SCLENITIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s autopsy perform death? 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After if filled in by the funer Natural 5 Pending work 1 🗌 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 0053051 E C 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Cedar Lane Walter Atha, M.D. Columbia, MD 21045 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 18 per inf 9922 12-29-11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ 2019 Dolan 8:16 Thomas Joseph AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Aberdeen Sea's of Compassion If Under 1 Year | If Under 24 Hrs. . Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months 7/24/1924 Pennsylvania 87 **Director** |93–18–1102 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Maryland Harford Aberdeen 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21001 1317 N. Stepney Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No þ 1 Never Married 2 X Married Specify: White Maryland 21215-0036 If Yes, Give 1943–46 Year or Dates. 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Salesman 12 Be 18. Mother's Name (First, Middle, Maiden Surname) Hubert Abbigail McCully Abbie Hubbert 17. Father's Name (First, Middle, Last) 2 Daniel Dolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1116 Chatelaine Dr., Fallston, MD 21047-2346 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Debra A. Shaffer / Daughter Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State West Chester, 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12/23/2011 R.A. Ferris & Co. Pennsylvania Tarring-Cargo Funeral Home, P. 333 S. Parke St, Aberdeen, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (o Exami attending physician and I for use as the burial-transit Cause (Disease or linjur) that initiated events resulting in death) Last Due to (or as a consequence of) 000 Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death detached the Unknown signed by Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen Were autopsy findings available prior to completion of cadse of death?

1 Yes 2 24a. Was an page 2 s autopsy performed this certificate has 1 Yes 2 funeral director, 25. Was case referred to 26. Place of Death (Check only one) Be examiner? Assisted Hospital Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manna of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After iniury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M. D s of person who completed cause of death (Item 23a) (Type, Print 30. Name and addre mp 911/2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DURHAM Medical DECEMBER 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours **Director** 213-11-0800 1 □ M 2 🕱 F 37 02/22/1974 WASHINGTON, DC 28a-f show at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits PRINCE GEORGE'S MARYLAND LANDOVER 1 X Yes 2 No Ь 10f. Zip Code 10g. Citizen of What Country? or items 23a 6705 EL PASO STREET 20785 UNITED STATES Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Divorced Specify. BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) CHEMICAL ANALYST PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ORLANDUS DURHAM HATTIE STEED 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau ANTHONY OVERTON / HUSBAND 6705 EL PASO STREET, LANDOVER, MARYLAND 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/30/2011 LANDOVER, MARYLAND 4 Donation 5 Other (Specify) HARMONY CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD. HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FATAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 P g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 R/Outpatient 3 DOA completely filled in by the funeral Manner of Death s after death. Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Division Accident 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Exami : On the basi examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nu Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE CHEVERLY, MU MD 31. Date filed (Month, Day, Year)
DEC 2 8 2011 State Registrar

PATIENT KNOWN AS ASCHIRED DUR. PO. Box 68760

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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🙀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cer	metery crem Wes	patory or othe L Arun	deI	Dec	ember 22 2011	,	,	aryland			
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Ä	permit Depar Impor any in		MARIE ()	Donaldson Funeral Home & Crematory, P.A.  1411 Annapolis Road, Odenton, Maryland 21113												
	Physician/ Medical Medical Examiner  e pnial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due t	a conseque	ince of): Ir	HOTY	ion	<del>5 T CLC</del> 1 <del>7 DVS6</del>	TION APPROVED B	young	1 And	Onset and Death			
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amend item 1 per doc 19a, b per 15h, 8922 12 12 128 11 vt

State of Maryland / Department of Health and Mental 1788 11 vt For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical **Examiner** 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Baltimore 3704 Springdale Avenue Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 0-22-1158 Director 1 🗆 M 2 🔀 F LORIDA permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mertal Hygiene. In fine prants if tien 27 is anaked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Funeral Director 1 XVes 2 □ No BALTIMURE 10e. Street and Number 10g. Citizen of What Country? 21216 SPRINGDALE AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 1. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) SEWING Elementary/Secondary (0-12) College (1-4 or 5+) S'EAMSTRESS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OSCAR STUDSTIL (UNKNOWN a Informant's Name/Relationship (Type, Print)
Glenda Evans- daughter-in-law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3704, Springdale Ave. Baltimore, Md. 21216 OSCAR 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 105/2012 OWINGS MITTS, MARY LAND 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST CEME 22. Name and Address of PATRY E DERRICK C. JONES FIH, P.A., 4611 PARK HGTS. AVE., BALTIMORE, MARYIAND Squature of Funeral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) use at the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 2 No Division of Vital the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: ပ 4 ☐ Nursing Home 5 Nesidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 🗌 Yes 2 🗌 No 5 Pending Accident Investigation 2 Accider
3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: my knowledge, death occurred at the time, date and place, and due to 29b. Signature State Registrar

		Please Type or Print in  State of Maryla  1 - State Registrar	nd / Depa		lealth and	Mental Hy		ible.	,	
Physicia Medic	al	1. Decedent's Name (First, Middle, Last)  Dennis Edwin Funk				2. Date of Dec Month	er 24 2	3. Time of Death 2011 8:00 A M	1	
Examin		4a. Facility Name (if not institution, give street and number)  1728 White Oak Ave.  5. Social Security Number   6. Sex   7. Age (In yrs.)	last hirthday)	4b. City, Town, or Baltimo			4c. County Balti			
Funeral Director		212-50-0725  Usual Residence of Decedent 1x M 2 □ F 64	Yrs.	Months Days	Hours Min	. (Month, Da		Year) Country)		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Anotactari: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Funeral	1728 White Oak Ave.  11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  172. Was Decedent Ever in U Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates.		Was Decedent of His If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	Blac	USA e - American Indian, kk, White, etc. White		
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uld be filed d Mental Hy marked oth natic even	To Be	17. Father's Name (First, Middle, Last)  Wade Henry Funk			Betty		rner			
l and 2 sho f Health and item 27 is o other traur		19a. Informant's Name/Relationship (Type, Print)  Mrs. Joe Anna Funk/ Wife  20a. Method of Disposition  20b.	1728	ng Address (Street a  Nhite Oa  District (Name of	ak Ave.		e, MD.			
mit. Page lartment of sortant: If i injury or se.		1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fineral Service Lifenses	lson U	.M. Ceme to 2. Name and Addres	ery 12-			reen, MD.	_	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ HRISTINE IRGASON 0606M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 10702 Begonia Lane Bowie If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Min (Month, Day, Year) **Director** 339-52-3409 1 □ M 2 🕱 F 55 10/02/1956 Illinois Usual Residence of Deceden 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ıral", or items 23a or Examiner must be r Funeral U.S.A. 10702 Begonia Lane 20720 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 'natural", 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Government Import Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h မ Margery Ann Queckboerner other traumatic Robert Lee Roy Furgason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a 10702 Begonia Lane, Bowie, MD 20720 <u>Justine Ameral / Spouse</u> Department of He Important: If its any injure 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 12/27/2011 | Hanover, Maryland 4 X Donation 5 Other (Specify) Anatany Gifts Registry Funeral Service | icensee Anatomy Gifts Registry 21. Signature 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events Due to (or as a consequence of) death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the ding place IE FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ō Month Year Pregnant at time of death signed by the at d be detached fo Unknown 9 Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 certificate has autopsy performe death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Affed in by the fu M Accident
Suicide Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huy Kurpelis Mozico.

Registrar DHMH 17 Rev 06-2011

State

c 110/

32. Registrar's Signature

CE 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month GROSS MAE 1100A ANNA DEC 2011 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth **Funeral** Months (Month, Day, Year) Hours 438-20-6890 Director 1 🗆 M 2 😿 F 10-16-1925 Louisianna 86 Usual Residence of Decede 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Sykesville 1 Yes 2 X No MD Howard 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13965 Forsythe Road 21784 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛣 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: Completed 3 X Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Andrew R. Norman Pearle Shriver permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number; City or Town, State, Zip Code) 3215 Bennett Point Road, Queenstown, Maryland 21658 Donald P. Gross - son Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Meadowridge Mem Park | 12-30-2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Light 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Sign MMP, Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE PANCREATITIS Physician/ 2 DAYS disease or condition Medical resulting in death) Due to (or as a consequence of Examiner **YEARS** ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine YEARS sician and burial-transit death certificate be executed Cause (Disease or injury that initiated events HYPERTENSION Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 the as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Box in the past 12 months? for Month Day 9 Unknown ed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe be d 2 Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy performed 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. ☐ Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by determined filled in 24 hours a Funeral C Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. etely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) INTENSIVIST oday-B. Navourty D0051119 DEC 24,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
UDAY BNANAVATY, MD HOWARD COUNTY GENERAL HOSPITAL
5755 CEDAR LANE, COLUMBIA, MD 21044

Year

121

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature Tenn B. fack

	A	Please mend # 9,11.12,15-	Type or Pringle 22 State of Ma	nt in Blac I <b>C923</b> aryland / I	k Indelible 1/23/12 TR Department of	Ink. Ens Health	<b>ure All</b> and Me	Copies ental Hyg	s Are Le	gible.		
Physici Medi		1 - State Registrar  1. Decedent's Name (First, Middle, Las  RICARDO E	ot)	Gask	Certificate o	of Death	2	Date of Dea Month	Death Day Year 3. Time of Death			
Examil Funeral Director		4a. Facility Name (if not institution, give  5. Social Security Number  6. S  213-64-7096	ex 7. Age	(In yrs. last birtl	4b. City, Tow	rear If Under ays Hours	24 Hrs. 8 Min.	Date of Birt	:h y, Year)		h hplace (State or Foreign untry) <del>unk</del> y <b>1and</b>	
ne Maryland or 28a-f show onotified at	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD  10e. Street and Number		10c. City, Town	or Location Ltimore	de		Oct 3,	1933		10d. Inside City Limits	
ite; Widl yidlid ZIZIS-0000 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	821 Eutaw St.  11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2  If Yes, Give Year or Dates.	ver in U.S.	13. Was Decedent If Yes, specify 0	of Hispanic Ori Cuban, Mexicar	, Puerto Ric	y Yes or No- can, etc.)	В			
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1 and 2 sh of Health a fitem 27 is		20a. Method of Disposition	ledical ct	20b. Place of	Disposition (Name or crematory or other	f	Bal		20c. Locatio			
permit. Page 1 and Department of Hed Important: If item any injury or othe		1 ☐ Burial 2 🗶 Cremation 3 ☐ 4 ☐ Donation 5 🖾 Orner (Special Control of Funeral Contro	yin state	On-si	re Cremato	ry 1	yState	Anat	Baltin omy Por ltimore	Ird J	oseph H. Br	
Ph _{sician/} Medical Examiner	Je.	23a. Par 1. Enter the disease, or comshock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or as a	consequence of	ot enter the mode of  Infarch if):	dying, such as					Approximate Interval Between Onset and Death	
ate be executed physician and the burial-transit	edical Examiner	if any, leading to immediate outco. Electron comping Cause (Disease or injury that initiated events resulting in death) Last	C	consequence c								
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ling Physician: The After this certific funeral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆 ER/Ou	tpatient 3 ☐ DCA	6. Place of Dea Other: 4 □ No			dence 6 🗆 C	ther (Spec	ify)	
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To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nur	L sician: To the best of r ner: On the basis of ex se Practitioner: To the	amination and/or	r investigation, in my	opinion, death or	ccurred at the	e time, date a	and place, and	due to the	cause(s) and manner sta	
To the I within 2 To the I complex		29b. Signature and title of certifier			RE	ense number	01		29d. Date sig	ned (Monti	201(	
Sta	te	30. Name and address of person who vice m Bhasin 31. Date filed (Month, Day, Year)	22 South		Type, Print) Street Ba	Himore,	MD					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 41457 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GORDON IRIS 5 7:30 E. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** GOOD SAMPLITAN HOSPITAL PORE CIT BARDMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Months Hours Min (Month, Day, \) Director ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. 9 ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 0115 of Health and Mental Hygi item 27 is marked other other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1AUS-DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Part / Phter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CARSIAC ARREST disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HYPOTENSION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events SERSIS and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Month Pregnant at time of death VIA Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 6-known Division of Vital Records, Completed and stage rend direase 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe has within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 2 No 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00066548 2011

Registrar

DHMH 17 Rev 7/2009

State

back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

GOOD SAMARITAI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 State of Maryland Department of Health and Mental Hygiene 20 |

41459

			For State Registrar	State of	Maryland / Dep	rtificate of De		Reg. N		4140-
å	Physicia		1. Decedent's Name (First,	Middle, Last)  Soon Hong	H	HAG		Date of Death Month CEMBEL	ay Year	3. Time of Death
C. Car	Medic Examin		July	itution, give street and numb	HASNI tal	4b. City, Town, or Loc	cation of Death	. 40	c. County of Death	ed
	Funeral		5. Social Security Number	27	Age (In yrs, last birthday)		Under 24 Hrs. 8, lours Min.	Date of Birth (Month, Day, Year)	9. Birth	place (State or Foreign try)
	Director	L	219-89-24/1 Usual Residence of Dece	1 M 2 XF	75 Yrs.		-	3/13/3		OREA
	Maryland 28a-f sh etified a	Director	10a. State 10b. 0	bunkd	10c. City, Town or L	ILS VILLE	-			0d. Inside City Limits  1  Yes 2 □ No
	with the l 23a or 2 ust be no	Funeral Di	10e. Street and Number	TE YOYAG	F WAX	10f. Zip Code 210Z	9	10g. C	itizen of What Cour	itry?—A
9800	e filed within 72 hours after death with the Maryland that Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2  3 Widowed 4 Di	✓2. Was Deced Armed Ford 1 ☐ Yes	es? 2 No	Was Decedent of Hispa If Yes, specify Cuban, № 1 ☐ Yes 2 No S	flexican, Puerto Rica	Yes or No- an, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	i 72 hou an "natu Medical	Completed	(Specify onl	ecedent's Education v highest grade completed)	(Give	edent's Usual Occupation kind of work done during DO NOT use retired)			Kind of Business/In	
	ed within Hygiene. other thai	ا م ا	Elementary/Secondary (  17. Father's Name (First, M.	7	11/	VESTIN	New Z		5 US/14	1255
Maryland	ould be file d Mental   marked c matic eve	P P	EUN S	oo Ho	Ho Eue	Hong	JOM	500	AHI	N
	12 shouth an and 27 is		19a. Informant's Name/Rel	ationship (Type, Print)	ARK 6000	ing Address (Street and	Number or Rural Ro	oute Number, City o	or Town, State, Zip (	12E, MD
nore,	of # to		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cren 4 ☐ Donation 5 ☐ C	nation 3  Removal from S	20b. Place of Disp cemetery, cre	osition (Name of matory or other place)	Date 12 - 2	<b>I</b>	ocation - City or To	own, State
Baltimore,	permit. Page Departmer Important any injury once.		21. Signature of Steep Se		LICAL 2	2. Name and Address o	11		ERAL	Home
			23a. Part 1. Enter the dise. shock, or heart failure	ase, or complications that ca List only one cause on eac	used the death. Do not en	ter the mode of dying, si	uch as cardiac or re	spiratory arrest,	p, ma	Approximate Interval Between
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	ertificate ling physe as th		IF FEMALE:	220 If yes outo	ome of prognancy					
D. Box 68	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  Within 24 hours after death.  The Funeural Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregna in the past 12 months' 1  Yes 2 No 9 Unknown	1 □ Live B 4 □ Pregn	ant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
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cord	law requias been	Completed						24a. Was an autopsy	prior to co	psy findings available impletion of cause of
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Vita	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 🗷 No	Hospital:	npatient 2  ER/Outpatie	Other:	Nursing Home	, ,	6 ☐ Other (Specify	v)
n of	ding Ph h. After thi funeral		27. Manner of Death  1 Natural 5	Pending 28a. Date o	·	28c. Injury at work?		. Describe how inju		,
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director,	Certificate:	3 Suicide 6		f Injury - At home, farm, st g, etc. <i>(Specify)</i>			Location (Street as City or Town, State	nd Number or Rura e)	Route Number,
	Hospital 24 hours ( Funeral I etely filled	Medical	29a. Certifier 1 Cer (Check 2 Me	tifying Physician: To the be dical Examiner: On the basis	st of my knowledge, death of examination and/or inve	occurred at the time, da	ate and place, and o	lue to the cause(s) time, date and plac	and manner as stat	ed. use(s) and manner stated.
	To the I within 2 To the I complei			tifying Nurse Practitioner:			me, date and place, mber	and due to the caus	se(s) and manner as ate signed (Month,	stated. Day, Year)
Ò	1/or		* Win	erson who completed cause	W 140		- 000	Dec	nuber 23	,2011
	V / V		NEEL SOL	HR	or death (Item 23a) (Type,	Print)	600 N. V	volfe St.	BaHIMO	re MD, 21287
	Stat Registra		31. Date filed (Month, Day,	2 8 2011 32. F	gistrar's Signature	harles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 41460 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Year Physician/ 5:50 AM 2011 helma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Catonsville 4c. County of Death Baltimore **Examiner** Charlestown Care Center 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Months Days Min 05-02-1917 1 □ M 2 🔀 F 461-30-5370 94 Director Yrs. Iowa Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Funeral Director must be notified MD Baltimore Catonsville 1 🗆 Yes 2 🗓 No 28a-f 0 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a with 709 Maiden Choice Ln RG228N U.S.A. 21228 items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iten Examiner Armed Forces?
1 ☐ Yes 2 🗓 No
If Yes, Give Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: "natural", 3 XWidowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Teacher Montgomery County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental I ပ Clark Moon Blanche Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Daniel T. Henry/Son 5726 Yellowrose Court; Columbia, MD 21045 or other 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or oth cemetery, crematory or other place 12-28-2011 tlantic Crematory Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Sterling Ashton Schwab Witzke . Signature of Funeral Service License ville, Ínc Catonsvill Edmondson Avenue: 23a. Part 1. Enter the disease, or comcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Ganou Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and I for use as the burial-transit Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year been signed by the a should be detached t 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 🗌 No 1 🗌 Yes 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 - No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29c. License number 0 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maiden 32. Registrar's S State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Ressie June **Holmes** December Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death quare more osedale 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Months Hours Director 214-30-4222 80 West Virginia Usual Residence of Decedent show 10a. State at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sl notified Maryland Baltimore Middle River 1 Yes 2x No 10e. Street and Number 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral 126 Earls Road 21220 USA items 2 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give land 21215-0036 2X No 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife 6 years Own Home injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Elmer Morrison Bessie Stacey Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara G. Bressi Daughter 6806 Leslie Road, Baltimore Md. 21220 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State December Morningside Cemetery Renick, West Virginia 4 Donation 5 Other (Specify) 30, 2011 Signalure of Furieral Service Licensee 2. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. methory 23a. Part 1. Enter the disease shock, or heart failule. L or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line Immediate Cause (Final Ph_sician/ Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Dua to for sequence of Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 🧷 To the Hospital or Attending Physician: The law requires that the death certificate be exi Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Month Year Dav Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed After this certificate Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Could not be within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Sertifying Nurse Practioner: To the best of my knowledge, death surred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and addres completed cause of death (Ite

State Registrar 31. Date filed

Day, Year,

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32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Randolph Hudgins 2011 3:15 John December PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7103 Dunshire Way Apt C3 Dundalk Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours August 15, Maryland 215-76-4299 Director 1 **X** M 2 □ F 53 1958 Yrs Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 ☐ Yes 2X No 10e. Street and Number ō 10f Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 7103 Dunshire Way Apt C3 21222 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White "natural", 3 Widowed 4 Divorced Specify Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 years Laborer Recycling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ဂ James F. Hudgins Marianne Lang traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a tem 27 i Ronald Hudgins Brother 234 Jenny Lane, Stewartstown, PA. 17363 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ŧ # 5 1 Burial 2X Cremation 3 Removal from State December permit. Page Department of Important: If any injury or Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 31,2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, of shock, or heart failure. Let Interval Between Onset and Death nly one cause on each line. Immediate Cause (Final Ph_sician/ Metastatic cance disease or condition muttes Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 2 No 1 Yes 2 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 2 🗌 No 1 Yes Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After atural 5 Pending injury 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 213 Browner, 10058838 December 28 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easten

State Registrar Here Browner, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Hooven, ALMA

			For State Registrar	State of Mary		artment			ental Hygi		_	41463
	Physicia Medic	al	1. Decedent's Name (First, Middle, Lass Alma E. Hoover						2. Date of Death Month December	Day 24	Year 9011	3. Time of Death 0 1 1 5 A M
-	Examin	er	4a. Facility Name (if not institution, give: BAITS wore Wash	witer Medic		(		Burn				undel
	Funeral Director		216-20-4332	T 3077 - 1	yrs. last birthday) 86 Yrs.	If Under	1 Year   If Under Days Hours	Min.	8. Date of Birth (Month, Day March 8	^{Year)} 925	9. Birthp Count Nort	lace (State or Foreign ty) h Carolina
	Maryland 28a-f show atified at	Director	Usual Residence of Decedent           10a. State         10b. County           Maryland         Anne         Ar		c. City, Town or Lo		-			1	0d. Inside City Limits 1 ☐ Yes 2 No	
	with the 23a or 2	Funeral Di	10e. Street and Number 171 Ryan Road	•		10f. Zip (	Code 122		10	og. Citizen o	f What Coun	try?
980	filed within 72 hours after death with the Maryland theylgiene. All Hygiene. All Hygiene. All theylgiene do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.			ent of Hispanic Or fy Cuban, Mexica No Specify		eify Yes or No- lican, etc.)	BI	ace - Americ ack, White, e	
Maryland 21215-0036	s filed within 72 hours after death with the Maryland Ital Hygiene. 3d other than "natural", or items 23a or 28a-f sho other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Seconday (0-12) 12		(Give	edent's Usual kind of work DO NOT use i emaker	done during mos	st of workin	g	House		dustry
land	I be filed fental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last)  Thurston Salley	,				ner's Name rgaret	(First, Middle, Mi		ne)	
Mary	of Health and Mental lof Health and Mental lof team 27 is marked crother traumatic ever		19a. Informant's Name/Relationship (Ty) Patricia L. Blaker	*		-			ral Route Number, City or Town, State, Zip Code) na , MD 21122			Code)
Baltimore,	permit. Page 1 an Department of He Important: If iten any injury or othe		20a. Method of Disposition 1 ☐ Burial 2	Removal from State	20b. Place of Disponentery, cre  Metro C	matory or oth	e of her place)	Ď	ec 26, 2011	20c. Location	n - City or To	
Balt	permit. Departr Imports any inji		21. Signature of uneral Sovice Ligens		2		Address of Facili ngs Fune:				nd 211	22201
.~. [	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart falure. List only of Immediate Cause (Final disease or condition	e glause on each line.	hre	ter the mode	of dying, such as	cardiac or	respiratory arres			Approximate Interval Between Onset and Death
angers"	Medical Examiner		resulting in death)  Sequentially list conditions,	Due to (or a a co	nsequence of):							
	s be executed /sician and e burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a co								
	cate be e physicia s the buri	edical		d								
P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  Of the Funeral Director Attent this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of p 1  Live Birth 2  4  Pregnant at tim 9  Unknown	Fetal death 3	Ectopic pr Other (spe	regnancy ecify)			23d. Date of delivery Month Day		
ds, P.O	quires that the series and by the detail	by	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the	underlying ca	ause given in Part	t I.				e cause of death?
Division of Vital Records,	The law rec cate has bee page 2 sho	Completed							24a. Was an autopsy perform	/ ned?		osy findings available impletion of cause of
/ital	sician: certific	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	lospital:	0 □ ED/0. tti-	-1 0 🗆 20	26. Place of Dea			• □ o		
n of \	ding Phy th. After this funeral o		27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Ye	2 ER/Outpatie 28b. Time c injury		c. Injury at work?	2	ne 5 Resider 8d. Describe hov			
Divisio	To the Hospital or Attending Physician: The law within 24 hours after deet.  To the Funeral Director Atter this certificate has completed filled in by the funeral director, page 2.	I Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)				-	8f. Location (Stre City or Town,		ber or Rural	Route Number,
	ne Hospi n 24 hou ne Funer	Medical	(Check 2' Medical Examir	cian: To the best of my ler: On the basis of examine Practioner: To the best	nation and/or inves	stigation, in m	y opinion, death o	occurred at t	the time, date and	place, and d	ue to the cau	use(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier  Hey	mes in		29c.	License number	15		d. Date sign		-
	2 dr		30. Name and address of person who co	ompleted cause of death			HE	de y	FRANC	i A	10	/ = -11
	Stat Registra	te ar	31. Date filed (Month, Day You) DEC 2 8 2011	Shington A	Signaturalle		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-17		13/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December Day 27 2011 Roseann Hoffman 10:15 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard 2615 Buckingham Road Ellicott City If Under 1 Year If Under 24 Hrs . Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days **Director** 154-32-9659 69 1 🗆 M 2 🕱 F 07/18/1942 NJ 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Ellicott City MD Howard 1 🗌 Yes 2 🏻 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21043 2615 Buckingham Road United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 X No à "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary NJ Bell Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental marked Alice Tolland William Goetzl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is 2615 Buckingham Road Ellicott City, MD 21043 Kenneth D. Hoffman - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite 1X Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 12/30/2011 Ellicott City, MD St. John's Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc any 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death
Years Ph_sician/ Metastatic Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \) \( \mathbb{X} \) No Day Month Year Pregnant at time of death the hed g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes Yes 2 V No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Accident Suicide Investigation 6 Could not be 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours to the Fune completely fi (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 27, 2011 ours MD D38565 ammi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tammi Davis, MD 9106 Philadelphia Road Baltimore, MD 21237 31. Date filed (Month, Day, Year 32. Registrar's Signature State DEC 28 2011 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 26, 2011 Raymond Rembold Hooker Jr. 7:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 316 Crestwood Drive Edgewood Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8. Date of Birth 1 🔀 M 2 🗆 F Months Hours (Month, Day, Year, Director 218-40-1952 1941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 316 Crestwood Drive 21040 USA. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental I ဥ Raymond Rembold Hooker Sr. Bessie Arlene Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gale L. Hooker / Wife 316 Crestwood Drive, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 12-31-2011 Towson, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MY IZCO DYSPLASZA Physician/ moutit! disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been sig page 2 should b Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{c}\text{Residence} & 6 \sup \) Other (Specify) 1 Yes 2 NVn 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier 1 Detrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 00058475 DECBABITA 27,2011 PITYSICEAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHZLIP NIVAT PUMIN, 502 UPPER CHAIS APRANTE DREUR, BILAZR, MD 21014

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 24, 2011 11:05P.M Thelma Mary Hutson Médical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 217-16-4821 Director 1 🗆 M 2 💢 F Jan28,1924 Maryland 87 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** 28a-f Md. Baltimore City Yes 2 No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a 618 South Lakewood Avenue 21224 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 5 þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 al Hygiene.
d other than "natural", o 1 ☐ Yes 2 🗓 No Specify: 3 ▼ Widowed 4 □ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other thar ir traumatic event, the N Elementary/Secondary (0-12) College (1-4 or 5+) 8th Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked o ည Priscilla Kantorski Michael Rachula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 South Lakewood Avenue Baltimore, Md. 21224 Val Hutson / Daughter or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of h Important: If ite any injury or ot once. December Burial 2 Cremation 3 Removal from State cemetery, crematory or other place CrossPNCCem. 29,2011 Baltimore, Maryland Donation 5 Other (Specify) M00933 22. Name and Address of Facility aczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ pulmonale Car ucc Medical **Examiner** Obs muchine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami use as the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No for the Hospital or Attending Physician: The law requires that the death Month Day the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) WSCC 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending the Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 25 2011

State Registrar

DY

M GOO N- Charles ST TOWSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

HARLES

31. Date filed (Month, Day, Valar)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 1.31 P M c Johnson 23 3011 December Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** Raltimor (Saltimore 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country) **Director** 1 □ M 2 🖫 F 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a, State notified at by Funeral Director 1 Nes 2 No 28a-f mar noun's Johnson, Gilde 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, artment of Health and Mental Hygiene. oortant: If item 27 is marked other than "natural", or iten injury or other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 [ If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Machine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Informant's Name/Relationship (Type, Print, Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number of Department of Health a Important: If item 27 is any injury or other trau once. onstance 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State altimore 4 Donation 5 Other (Specify) 21. Sign Juny of Funeral Sanice Lonsee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ocodia Ph_sician/ favot 100 disease or condition resulting in death) Medical Examiner money Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): the attending physician and ched for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnal Pregnant at time of death 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year 2 No 1 Yes 2 9 Unknown be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has filled in by the funeral director, page 2 autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Obesity Yes 2 No 2 🔀 No 1 🗌 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital 4 Nursing Home 5 Residence 6 Other (Specify) ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 34931 12/23/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore MD Z1236 4136B E Jo Nosi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month nnsor :45 AM December Medical Facility Name (if not institu give street and number. 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ammore Imonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 216-42-2429 **Director** 1 □ M 2 🖼 F 67 Yrs permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No Homore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Harton 21214 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 23, 2011 2:45 a.m. Maryland 21215-0036 Black, White, etc. Completed by 1 Never Married 2 ☐ Married 1 Yes If Yes, Gir 2 No Blac 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204 19a. Informant's Name/Relationship (Type, Print) tokes Baltimore, DECEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremator, or other p 20c. Location - City or Town, State ⇒ □ Cremation 3 Removal from State 4 Donation 5 Other (Specify) of Funeral Service Lig 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line terval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) UTERINE CANCER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Disaste for as a persecution pour attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be DOROTHY JOHNSON | Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an autopsy has page 2 this certificate ☐ Yes 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ၉ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) X Natural 5 Pending work? 2 No M Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Çertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and titl 29c. License number 29d. Date skined (Month, Day, Year) 201 1an who completed cause of death (Item 23a) (Type, Print) 30. Name and address 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 JONES, CRNP 31. Date filed (Month; Day, Year) State Registrar

Division of Vital Records, P.O. Box 68760, To the Funeral Director: in by the

2

Sa

State

Registrar

Accident

Ling Li, MD

29b. Signature and title of certifier

31. Date file 10 tt 2 8 2011

3 Suicide

4 Momicide 29a. Certifier 1

Investigation

Could not be

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

DHMH 17 Rev 1/2001 **OCME 2006** 

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

(Specify) Multi-Family Apt.

32. Registrar's Signature

and manner stated.

28f. Location (Street and Number or Rural Route Number, City

December 11, 2011

29d. Date signed (Month, Day, Year)

or Town, State) 2503 N. Violet Avenue Apt. 704 F, Baltimore , MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 00.45PM 20/1 De Center Medical or Location of Death County of Death **Examiner** Dwas elumbis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State of 8. Date of Birth 7. Age (In vrs. last birthday) oreign **Funeral** Months Hours Min Director 510 12 8557 1 XM 2 F Kansas 93 Feb. 22, 1918 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No MD Howard Columbia ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 5400 Vantage Point Rd #1113 21044 United States Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. 0 δ 1 Never Married 2 X Married If Yes, Give 1940-68 Year or Dates. XYes 2 Yes, Give 1 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify "natural", Specify: Completed 3 Widowed 4 Divorced White traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Naval Aviator US Navy Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I မ Della Swanson Oliver Conrad Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Clifton E. Jackson, Jr./Son 24609 Deep Water Point Dr. St. Michaels, MD 21663 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o ☐ Burial 2 【XCremation 3 ☐ Removal from State Ardent Cremation Svc. 12-27-2011 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc, 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the attending physician and shed for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the at Id be detached for g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No Yes 2 filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient this 28a. Date of injury (Month, Day, Year) 27. Manner T Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Director: After Natural 5 Pending 1 Tes Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined after Hospital within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

030641 29b. Signature and title of certifier 2 RIVE Mcck Road /09

Registrar

31. Date filed (Month, Day, Year) **DEC 2 8 20**1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For Stete Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 08:13 A M December 13, 2011 Sarah Jane Jakielski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ Virginia 228-75-1167 15 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State itam 27 is markad other than "natural", or itams 23a or 28a-f show other traumatic avant. The Modical Exercit art must be confilled at 1 Yes 2 No Director VA Fairfax Lorton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10628 Anita Drive 22079 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after ☐Yes 2 X No Yes, Give 1 X Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 h and Mental Hygiene. 7 Is markad othar than "r Elementary/Secondary (0-12) College (1-4or 5+) Student **Higher Education** 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Watsek Philip Jakielski P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an 10628 Anita Drive, Lorton, VA 22079 Mary Jakielski-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important; If any injury or once. 12-20-2011 Triangle, VA Quantico National 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Mountcastle Turch Funeral Home 4143 Dale Boulevard, Dale City, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-transit the attending physician thed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No. 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2/200 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3□ DOA filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attanding P 24 hours after death. a Funaral Diractor; After t Certification: 1 Natural 2 Accident 5 Pending investigation M 1 🗌 Yes 2  $\square$  No 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

State

Registrar

29b. Signature and title of certifier

30. Name and address

SACC O LOWNORTH WOIESTREET BOUTHINGE Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year)

rdonek

of person who completed cause of death (Item 23a) (Type, Print)

To the I within 2

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

29c. License number

D10951

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 41472 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Physician/ 2011 3:23 A M Kathleen Patricia Jenkins Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs, last birthday) **Funeral** (Month, Day, Year) Months Days Hours Min 214-46-7509 **Director** 1 🗆 M 2 🔀 F March 3, 1947 Maryland 64 Usual Residence of Deceden show 10d. Inside City Limits 10c. City, Town or Location at 10a. State 10b. County ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified 1 Yes 2 XNo Maryland | Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2909 Whitefield Road 21028 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?

☐ Yes 2 

☑ No 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Training Coordinator U.S. Government and Mental Hygier is marked other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Louis Back Mildred Elizabeth Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra 1805 Bet Twice Circle, Havre de Grace, MD 21078 Kristine Jenkins-Hagy/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1  $\square$  Surial 2  $\square$  Cremation 3  $\square$  Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn 12-28-2011 | Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kathleen Physician/ Snack disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events southing in death) Last Examine Kidney Due to (or as a consequence of): resulting in death) Last Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 L Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ infarction myocardial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No atrial fibrillation 24a. Was an m00013840 To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performe Thrombo cyropenia Ves 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28d. Describe how injury occurred injury 5 🗀 Pending 1 A Natural 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and Ne of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0065421 December 24, 2011 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Drive, Bel Ar, MD 21014 0 R. Fistler 500 Upper 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year // Physician/ Month 12 SON  $^{\prime}m$ 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore N/A 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 M 2 F 11/9/07/19/46 212-46-4471 Maryland Director Yrs 65 Usual Residence of Decedent 28a-f shov ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral death with 827 Arlington Ave. 21217 U.S.A. items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Force or Black, White, etc. þ 1 Never Married 2 Married Yes 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", If Yes, Give Specify: 3

▼ Widowed 4 □ Divorced Completed Black Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 10th Grade Housewife N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, മ Calvin Atkins Laura Levi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 s t of Health a If item 27 i 8826 Stonehaven Rd., Randallstown, MD 21133 Roland Hicks(Brother) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) on-site Crematory 12/27/11 Baltimore, MD Sign ture of Funeral Service Licensee 2765ephdr# of Fabrown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between rediate Cause (Final Onset and Death Phyllician. disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami law requires that the death certificate be executed resulting in death) Last sequence of attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) signed by the a ld be detached f Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown s been signated the 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an Jas page 2 autopsy Hospital or Attending Physician: The certificate Yes 2 N 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 2 X No 1 🗌 Yes After this o ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident injury 5 Pending s after death.

I Director: Af M Investigation 6 Could not be ithin 24 hours after de the Funeral Directo mpleted filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the land within 2 3 only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) orank Print) Name and address of person who completed cause of death (Item 23a) (Type, 31 State

DHMH 17 Rev 7/2009

Registrar

William A. Johnson III 12/22/2011 1800 HRS

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Division of Vital Records,	Attenor death ctor: /	Certificate:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju	ury - At hon	ne, farm, stre	M 1 L	Yes 2 □ No	28f. Location (St	reet and Numb	er or Rural Route Number,
Divi	ital or ars after al Dire		4 🗀 Homicide	deterrimed	building, etc	c. (Specify)				City or Town	n, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 (Check 2 only one) 3	Medical Exami	sician: To the best of ner: On the basis of e se Practioner: To the	xamination	and/or invest	igation, in my opini	on, death occurred at	the time, date an	d place, and du	ie to the cause(s) and manner stated
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10			30. Name and address	s of person who on $\mathcal{N}_{\mathcal{I}_{i}}$	1 1 -	eath (Item :	23a) (Type, P	rint) ((CT. LL+	-how lle	Md Z	[1093	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles Kuhn Decembe Medical County of Death 4a. Facility Name (if not institution, give street and number) wn, or Location of Death Examiner Igip da If Unde 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex In vrs. last birthday If Under 24 Hrs. **Funeral** Months (Month, Day, Year) Director 215-18-7900 1 🔀 M 2 🗆 F 90 February 14,1921 Maryland Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director notified 28a-f Maryland Baltimore Middle River 1 Yes 2 X No P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 905 Oakdene Road 21220 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Chemical Company 12 years Chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret Gleich George A. Kuhn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Kenneth P. Martino 905 Oakdene Road, Middle River, Maryland 21220 Friend or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dundalk,Maryland Sacred Heart of Jesus 30., 2011 Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Signature of Funeral Service Licensee) . Do not enter the mode of dying, such as cardiac or respiratory arrest, or complications that caused the death 23a. Part 1, Enter the dise Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Let Examine Due to (or as a consequence of) sician and burial-transit as a consequence of resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death ed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed?/ Yes 2 No 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No ည ☑ Inpatient 2 □ ER/Outpatient 3 -4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pendina 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥ SUMANTOSOM 1212211 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saltimore MD. 21237

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

DEC 28 2011

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 3:35 AM James December 2011 Vincent Kressler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard Columbia Gilchrist Hospice Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours (Month, Day, Year) Director 213-32-5955 1 XM 2 - F 11/13/1936 Washington, DC 75 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Howard MD Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21044 U.S.A. 6336 Cedar Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married þ Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🛣 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Television 4 Journalist 1 and 2 should be filed wit if Health and Mental Hygie item 27 is marked other Be Unknown 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 34 Ridge Road, #E, Greenbelt, MD 20770 Bill Van Ormer / Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 12/27/2011 Hanover, Maryland Anatomy Gifts Reg. 21. Signature of Inneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a, Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Part 1. Enter the disease of complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ mplications 20 KS Medical resulting in death) Due to (or a a consequence of) Examiner )ementio Years Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of Exami sician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
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3 Suicide Investigation 6 Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 2104 CEDAR LANE JUSEPH State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month Day 18:06 PM KREPNER **Physician** LEEN DECEMBER 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore**  Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F 74 213-34-7041 Vrc <u>Maryland</u> Mar1,1937 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 ¥ Yes 2 □ No Director Md. Baltimore City 10f, Zip-Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 5923 Fairwood Avenue 21206 Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than Restaurant Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be 1 lealth and Mental I Frances Beale ပ <u> Harry J. Elliott</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5923 Fairwood Avenue Baltimore, Md. 21206 Daniel Krepner Son Important: If item 2 any injury or other once. December | 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 23,2011 |Baltimore,Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facilitiaczorowski Funeral Home, P.A. M00933 Rohn 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HUPOXIC RESPIRATORY **Physician** 27 MINITES /Medical Due (or as a consequence of): **Examiner** ATELECTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal dea ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 Yes 2 No 9 Unknown Pai þ Completed

Box 68760 P.O. Division of Vital Records, of or Attending Fafter death.

Director: After filled in by To the Hospital within 24 hours a To the Funeral D

Baltimore, Maryland 21215-0036

9 _ OTKHOWII										
Part II. Other significant	conditions con	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.		se contribute to the cause of death?  No 3 Probably 4 Unknown				
					24a. Was an autopsy performed? 1 ☐ Yes 2X No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No				
25. Was case referred to	medical	26. Place of Death (Check only one)								
examiner? 1 \( \text{Yes}  2 \( \perp \) \( \text{Vo} \)		lospital: 1 Inpatient 2	ER/Outpatient 3 .	OOA Other: 4 Nursing	Home 5 ☐ Residence 6	5 ☐ Other (Specify)				
27. Mann of Death 1 Natural 5 [ 2 \sum Accident	Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred				
3 Suicide 6 4 Homicide	Could not be determined	28e. Place of injury - At ho building, etc. (Specify		28f. Location (Street and City or Town, State)	8f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a, Certifier 1	Certifying Phys	sician: To the best of my kno	wledge, death occurre	ed at the time, date and place	ce, and due to the cause(s)	and manner as stated.				

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REG - 000

DECEMBER 21,2011

29d. Date signed (Month, Day, Year)

ana 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4940 Eastern Avenue, Baltimore, MD, 21224

State Registrar

မ 27

Certification:

Medical

DEC 2 8 2011

M.D

and manner stated

		Please T	* *	Indelible Ink. Ensure		
		For	•	epartment of Health and	Mental Hygien	e 2011 41478
		State Registrar	<u> </u>	Certificate of Death	Reg. N	
Physic Med		1. Decedent's Name (First, Middle, Last)	LEVINE	3	2. Date of Death  Month  DECEMBER	Day Year 3. Time of Death 26 2011 9 00 AM
Exam		4a. Facility Name (if not institution, give st. 70) Rosedale	Street and number)	4b. City, Town, or Location of Death	1 4	c. County of Death
Funera Directo	_	5. Social Security Number 6. Sex	M 2 7. Age (In yrs. last birthday Yrs	Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country)
nd thow at	į.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location	111.75	10d. Inside City Limits
Maryla 18a-f s	rect	MD	Balti	more		1 ☐ Yes 2 ☐ No
vith the 23a or 3	Funeral Director	701 Rosedale	Street	10f. Zip Code 21216	10g. C	Citizen of What Country?
eath v tems er mu	F			13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,
Fe, Maryland 21215-UU30  I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ğ	1 ■ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ ₩6 If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ No Specify:		Black, White, etc. Specify: Black
2 hour	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a. Do	ecedent's Usual Occupation live kind of work done during most of wor e. DO NAT use fetired)	rking 16b.	Kind of Business Industry
vithin viene.		Elementary/Seconday (0-12)	Connege (1-4 or 5+)	e. DO Not use retired)	Ke	hab facility
Viand of the view of the view of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other o	To Be	17. Father 9 Name (First Middle, Last)	1.	18. Mother's Nar	me (First, Middle, Maide	n Surname)
Maryis 2 should to the and Me 27 is mark traumatic	li.	192. Informant's Name/Relation in (Type	a, <i>Print</i> ) 19b. N	Mailing Address (Street and Number or Ru	1.0	or Town, State, Zip Code)
e, M and 2 s Health s tem 27 i		Janea Lee Mull 20a. Method of Disposition	en Daughter) 70	1 Kosedale Street	t, Baltin	Location - City or Town, State
O 1		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		crematory or other place)		indsor Mill, ma
Baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe	i ce	21. Situature of Funeral Service License	Plane	2 Varie and Aldress of Pacilii	egre type	ral Services (e (21229)
<b>a</b> 60 = 66	OI .	23a. Part 1. Enter the isease, or compli	cations that caused the death. Do not		_	Approximate
- Physician	M,	shock, or heart failure. List only one immediate Cause (Final disease or condition	cause on each line.  ATKEROSCL		ASCULAR I	Interval Between Onset and Death
Medica Examine		resulting in death)	Due to (or as a consequence of):			7, 11, 13
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
and I-transi	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence of):			
te be ex ysician	<u></u>		·			
bb/rest ifficat ding ph	/Mec	IF FEMALE:	3c. If yes, outcome of pregnancy			23d. Date of delivery
<b>DIVISION OT VITAI RECORDS, P.O. BOX 68/00</b> To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
that the ined by the detack	by Pr	Part II. Other significant conditions con				o use contribute to the cause of death?
rdS, equires een sig nould b	eted		RENAL DISE			2 No 3 Probably 4 Unknown
OT VITAI HECONTAS,  ng Physician: The law requires ter this certificate has been signeral director, page 2 should b	Somple	VENOUS TH	ROMBO EMBOL	IC DISEASE	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No
cian:	a	25. Was case referred to medical examiner?	ospital:	26. Place of Death (Che	eck only one)	
Physi Physi this o	은	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outp  28a. Date of injury 28b. Tim		Home 5 Residence 28d. Describe how inj	
ON O	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) inju		200. Describe now my	ury decemed
DIVISION tal or Attendir rs after death. al Director: Af ed in by the fu		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
e Hospit 124 hour Funera leted fille	Medical	(Check 2 Medical Examine	er: On the basis of examination and/or in	ath occured at the time, date and place, nvestigation, in my opinion, death occurred lge, death occurred at the time, date and p	at the time, date and pla	ce, and due to the cause(s) and manner stated.
To the Voithin To the COMP	2	29b. Signature and title of certifier		29c. License number	29d. [	Date signed (Month, Day, Year)
n		30. Name and address of person who co	moleted cause of death /Item 23ch (Tim	D 4 4 510	I D	ECEMBER 28, 2011 RD MD 21228
3		M'VASANTHALC	uman MD. 501	FE 107, 516. N	Rolling 1	RD MD 21228
St Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature			

4AM

12-26-11

Jane Devine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical ame (If not institution, give street and number) Location of Death **Examiner** Coure 101 MX  $\omega$ 8. Date of Birth (Month, Day, Year)
July 22,1927 5. Social Security Number 220–26–2972 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. las Funeral Min. 1 □ M 2 🕱 F Months Days Hours Alabama **Director** 84 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Examiner must be notified at 1X Yes 2 ☐ No Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or USA 21217 2108 Park Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Mostles Experiment injury or other traumatic event, the Mostles Experiment. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🎦 No Specify: Specify: Black 2 3 XWidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) London Town Elementary/Secondary (0-12) College (1-4or 5+) Welt Setter Manufacturing 10th grade 17. Father's Name (First, Middle, Last) Ike Jackson 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3527 Woodmoor Road Baltimore, Maryland 21207 Bessie Mae Scruggs/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 29/11 Owings Mills, Maryland Garrison Forest Vet. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Chatman-Harris Funeral Home Heri 5240 Reisterstown Road Baltimore, MD 21215 23a. Part. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical e to (or as a consequen a of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ue to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ cate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Division of Vital 1 ∐Yes 2 No 2 🗷 No 1 🗆 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1∐Yes 2 🗖 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27, Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 □Yes 2 □No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 29a, Certifie 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number laren Name and address of person who completed cause of death (Item 83a) (Type Print) TUIY State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dominic Joseph Leonardi, Jr. December 5:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Parkville Baltimore Morningside House If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 214-20-8801 Hours 1 × M 2 🗆 F Director 2/16/1926 85 Mary Tand Usual Residence of Deced or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Mary land Baltimore Towson 1 ☐ Yes 2 🔀 No ō 10e. Street and Numbe 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 2 Hampshire Woods Court 21204 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. Ь þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White ed other than "natural", event, the Medical Exa Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene, ⊶ther than " Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Contractor should be filed with and Mental Hygien ris marked other to Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 other traumatic Mary Drusano <u>Dominic Joseph Leonardi, Sr.</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or or any Mary L. LaCasse / Daughter 2 Hampshire Woods Court Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/30/2011 Most Holy Redeemer Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eureral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or the consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) sician a burial-Physician/Medical Division of Vital Records, P.O. Box 68760 phys. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 No ed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of _ath (Check only one) Hospital Other: 2 No 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Magner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending work?
1 Yes ours after death, leral Director: Af filled in by the fu Accident 2 🗌 No М Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signati erson who completed cause of death (Item 23a) (Type, Print OV filed (Month, Day, Year, State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 25, 2011 3:02 P M Thomas Robert Lindos Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Mary land Director 213-52-5902 1 **x** M 2 □ F September 11, 1947 64 Usual Residence of Dec or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No Maryland n/a Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral or items 23a 15 Hamill Road 21210 USA Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: White "natural". Specify 3 Widowed 4X Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Mortgage Banker Finance other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H is marked o ပ Guerino Christopher Lindos Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai once, Ms. Annlynn C. Best (Companion) 15 Hamill Road Apt. F. Baltimore, Maryland 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Hilltop Service Corporation 12/31/2011 Towson 21. Signatur In ral Servi 21204 22. Name and Address of Facility Ruck-Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part L Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ metastate ancer disease or condition resulting in death) Ments Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to minusulate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ____ Day Month Pregnant at time of death the 9 Unknown q Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗆 No 1 Yes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ဂ္ MOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this ë Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Certificat 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined ospital hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on d title of certifier Sign 29d. Date signed (Month. Day, Year) KLEMBER ZS ZOII  $\sqrt{r}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anson ma

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ 12/24/2011 7:32 A Medical ar 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Westminster Dove House Hospice Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Days 1 □ M 2 🛣 F 6/3/1927 Yrs Marvland **Director** 84 217-20-0507 Usual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No MD Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1911 Suffolk Road 21048 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or 1 ☐ Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify 3 X Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's I Isual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Madeline Bruckner Amos A. Korb 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 Suffolk Road, Finksburg, Maryland 21048 Mark W. Lahner / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Other (Specify) 12/27/2011 Baltimore, Maryland Bayview Crematory Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) [₫]Examiner Z mouth: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No signed by the atte Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🕻 No Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 KNo Other: 1 Yes 4 Nursing Home 5 Residence 6 R Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Yes 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie MAIPHE 000 382 78 OM who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Clarkeville Mis Robert Feut 21004 Month, Day, Year, **2** 8 2011 32. Registra 's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician/ Lewis Month W. John 7:48 F M 2011 December 21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Co Bloom assisted Living Columbia . Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 218-26-5584 **Director** 1 XM 2 - F Yrs. 01/17/1931 80 Virginia Usual Residence of Decedent 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d Inside City Limits Director Yes 2X No Howard Co. Columbia MD 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 8107 Tiderock Square 21045 U.S.A. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐No Specify. Specify: "natural", 3 Widowed 4 Divorced Completed Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. ementary/Secondary_(0-12) College (1-4 or 5+) Trucking Co. 12th Grade Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John B. Lewis Mary Anna Smith traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 11090 Wineglass Ct., Columbia, MD 21044 Steven Lewis(son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Cem. 12/29/11 Crownsville, MD ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Forephadiss of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 acqueline 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End-Stage PariLinsons Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to lot as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached for 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use gontribute to the cause of death? Completed by 2 № No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other:
4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work' 1 ☐ Yes 2 ☐ No after death.

Director: A the f Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours af

To the Funeral D

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MS Rajapanem. 1) 10053465 12/12/11 5203 Balhmore MD 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3x1 V 32. Registrar's lignate 31. Date filed (Month, Day, Year)

OEC 2 8 2011 Registrar

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Baltimore, permit. Page 1 and Department of Hear	Important: If i any injury or o	1	21. Signature of Fund al Service	Licensee			<del>22</del>	Name and	Addres	S of Facilit	K COM	MIINTTY					
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Executed executed	Medical Medical Examiner prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize prize	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due	ON CH ITO (OI as	a consequence a consequence a consequence	e of): Le Oi).	NE P	וראט	ONAR	1 O le	EACE	EXA	CERBA:		Onset and 2 Day	<del>%</del>
Box 68760	To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1	ive Birth	of pregnancy 2  Fetal de at time of deat	ath 3 🗌	Ectopic p	regnanc ecify)	y				23d. Date Mont			Year
P.O.	ned by e detad		Part II. Other significant condition										tobacco	use contrib	oute to th	ne cause of o	death?
rds,	en sig	ted	CHRONIC OBSTRU		Hor	WKA OI	SEASE	E, SIE	ZUR	e dis	order	, ~	Yes 2	2 □ No 3	∃ Prol	bably 4 🗌	Unknown
Division of Vital Records, ral or Attending Physician: The law requires s after death.	cate has be ; page 2 sh	Completed by	HYPOTHYROIDISM,	DEMENT	TIA							perf	an opsy ormed? 2	pr de	ior to co eath?	psy findings mpletion of a	available cause of
<b>/ital</b> /sician	s certif director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	Innati	ient 2 ER/	Outpation	+ 3 D DO		ace of Dea		only one) ne 5 🗌 Res	idonas	6 D Othor	/Canaih	d	
of \	fter this	ite: T	27. Manner of Death 1 ✓ Natural 5 ☐ Pendir	28a. D	ate of inju	ıry 28k	o. Time of injury		Bc. Injury	at at		8d. Describe					
r Attendii ter death.	rector; Ai by the fu	Certificate:		gation not be	ace of Inju	ury - At home, c. (Specify)		M eet, factory,	1 🗆	Yes 2		28f. Location (			or Rural	Route Num	ber,
Div pital o	eral Di		29a. Certifier 1 Certifying					anunad aki	ile a Alima a	1-1	1						
n 24 hc	le Fun	Medical	(Check 2 L Medical E	Physician: To the Examiner: On the Nurse Praction	basis of e	examination and	d/or invest	igation, in n	ny opinio	n, death o	ccurred at	the time, date	and plac	ce, and due t	to the car	use(s) and ma	anner stated
To the	To the		29b. Signature and title of certifie	r				29c.		number			29d. D	ate signed (	(Month, i		1
		ļ	30. Name and address of person		ause of d	leath (Item 23a	a) (Type, P	rint)	)F	BALTI	PIORE	2401				· ·	
F	Stat Registra	٠	31. Date filed (Month, Day, Year)*	<b>-4.4</b> 32		ar's Signature		, del	•		. 5,00	1				<del>- 1</del> (	21215

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12/23/2011 Rawleigh Morton 9:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 4712 Wakefield Road Baltimore 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **™** M 2 □ F Hours 2/23/1936 **Director** 216-36-8294 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD 1 X Yes 2 □ No Baltimore 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4712 Wakefield Road 21215 USA item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🄀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced SpecifAfrican-American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Assembly General Motors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Willis Morton Bessie Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 3505 Garrison Blvd., Baltimore, MD 21215 Raw;ene Williams / Daughter ..t. Page 1 an. Jepartment of Health Important: If ite-any injury c 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 12/28/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications the process the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.
To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 sis autopsy death? Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

DEC 2 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per PHY G926 4/13/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dec . 23, 2011 Month Physician/ Day Year 100 40 HM Doris M. Melvin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5604 Northgreen Road Baltimore Baltimore 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral Director** 215-18-5603 90 1 □ M 2 🕱 F Sept. 17, 1921 Indiana Usual Residence of Decede 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified 1 Yes 2 X No Maryland | Baltimore Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 5604 Northgreen Road 21244 USA items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner . or ) Black, White, etc. Completed by 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: "natural" 3 X Widowed 4 Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roy Rubright Margarite Klinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trac Jeanne Wolfe Daughter 5402 Valley View Court; Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) c Crematory | 12/28/2011 Glen Burnie, Maryla 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc 1630 Edmondson Avenue; Catonsville, MD 21228 Atlantic Crematory Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Atheroscherose Onset and Death Physician Co-diputicula Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to for as a nonsequence of: burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery for in the past 12 months? Month Day 1 Yes 2 L 9 Unknown detached the 9 Unknown P.O. ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should 24a. Was an 24b. Were autopsy findings available has page 2 autopsy prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of .28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending injury M Accident
Suicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registra 31. Date filed (Month, Day, Year) **DEC 2** 8 2011 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 4:30 P. M Elizabeth McNemar December Η. Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Morningside House Dorsey Hall Ellicott City Howard Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 219-03-6611 Director 1 M 2 X F Maryland March 26, 1919 Usual Residence of Decedent 28a-f show 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Howard Ellicott CIty 1 🗆 Yes 2 😾 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21042 <u>5330 Dorsev Hall Drive</u> or items 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married Yes 21215-0036 1 Yes 2 No Specify. If Yes. Give Specify: White "natural" 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) Teacher's Alde Balt, City Schools is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Beulah Durham Eugene Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 11615 Whitetail Lane, Ellicott City, Maryland 21042 Cathy M. Pinkston - Daug 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Meadowridge Mem. Park 12/22/2011 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 21. Signatule of Fu 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 7250 Washington Blvd., Elkridge, Maryland 21057 23a. Part 1. Enter the disease, shock, or heart failure. Lis se, or complications that succeed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Cardiovascular Disease Immediate Cause (Final AtheroScleroTic Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p I for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 2 No detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate I 2 No 1 Tyes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 Pother (Specify) Asin to 4 U မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No e Hospital or Attending P 124 hours after death. e Funeral Director: After the Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number D30641 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) obath (Item 23a) (Type, Print)

201-109 Back R IVEN Neck Road Lamesh

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph B. Mitchell Jr December 2011 12:14 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3128 W. Springs Drive #A Ellicott City Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 220-62-9433 Director 1 🖾 M 2 🗆 F 57 June 8, 1954 Portuga1 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Howard Ellicott City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21043 3128 W. Springs Dr; #A 12. Was Decedent Ever in U.S. Armed Forces 7 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married þ 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Verizon computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mant. Important: If item 27 is marked any injury or other transpone ပ Joseph Berlin Mitchell Sr. Mildred Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Sweet - sister 4706 E. Cambray; San Antonio, Texas 78229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) in state Signature of Funeral Service Licer 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sbock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ ia betes disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami coholism ig physician and as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ō Month Day Year Pregnant at time of death 1 Yes 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law is within 24 hours after cleath.
To the Funeral Director: After this certificate has E completely filled in by the funeral director, page 2.8 completely filled in by the funeral director, page 2.8 autopsy performe death? Yes 2 X No 1 Yes 2 X No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No Division Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 12-19-2011 062426 on who completed cause of death (Item 23a) (Type, Print) Columbia MD 21044 10710 Charter Drive MD Kosalil hevi

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Yes

Year)

68760

Box

P.O.

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 2011 09:45 December Lucille S. /Medical Mapp 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) Millersville
If Under 1 Year | Hunder 24 Hrs. T Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Hours Days 1 □ M 2 🔀 F 401-28-0561 90 30 Director Nov. Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: I firem a 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it. Medica Examinating to multified a 1 □ Yes 2 □ No Directo Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21122 181 11th Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐NO If Yes, Give Ye ar or Dates: 11. Marital Status 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glass Manufacturing Packer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Sexton Cains <u>Anna</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 181 11th Street, Pasadena, MD 21122 Lauriann Schoonover (Niece) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 2011 Baltimore, Maryland 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service Licensee 3111 Mountain Road, Pasadena, MD 21122 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine as the burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760. physician The law requires that the death certificate be Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) P.O. □Yes 2□No be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 Dolo Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 🗆 No certificate 1 □Yes filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **☆** 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: 27. Manner of Death To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural (Month, Day, Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of 037136 n who completed cause of death (Item 23a) (Type, Print) much Drive Cherty MO 2/6/9 30. Name and add 32. Registra s Sign

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Registrar

32. Registra 's Signature

30. Name and address of person who completed cause of death (Item 23a)

OCME

Victor Weedn MD JD

**DEC 28** 

**ORIGINAL** 

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 25 2011 6:40 Ам C. Earl Miller Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Timonium Baltimore Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Days (Month, Day, Year) DV. 5. 1926 Months Hours Director 85 217-22-5410 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ellicott City Howard MD. 1 🗆 Yes 2 ื No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21042 3959 Ducks Foot Lane **USA** 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Narried 6:40 A M. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Banking Mortgage Banker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl F. Miller Steinmeyer V. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Miller/ Wife 3959 Ducks Foot Lane Ellicott City, MD. 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 15 Other (Specify) Garrison Forest VA 1-4-12 Owings Mills, MD. ^{22. Name and Address of Facility}
Ruck Towson Funeral Home,
1050 York Rd. Towson, md. 21. Signature of Fineral Sa vice Lip 23a. Part 1. Inter the disease, of complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to in models cause. Enter Underlying Due to for as a consequency of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t lirector, page 2 s autopsy performed Yes 2 death? 2 2 No ☐ Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours and To the Funeral Completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Irem 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 ERNESTINE WRIGHT, M.D. 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 11:35A M December <u> Allison Christine</u> Mangold Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchey Hospice House Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Months Days Director 208-61-2895 1 M 2 X F 05/28/1957 Maryland 54 Usual Residence of Decede 28a-f show 10a. State items 23a or 28a-f sho ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Glen Burnie MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 878 North Shore Drive 21060 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten idical Examiner r 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Specify: White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Magazine Editor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Faion Lott Wilson Margaret of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Dana Mangold / Daughter 2000 Kurtz Avenue, Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗌 Burial 2 🗀 Cremation 3 🗎 Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) 12/27/2011 Hanover, Maryland Anatomy Gifts Registry Signature of Funeral Service Lick see 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate val Between Immediate Cause (Final eath Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No Records, 1 Tes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy perform Yes or Attending Physician: 25. Was case ref ed to edica! of Vital Be 26. Place of Death (Check only one: 2 12 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? Division 1 🗌 Yes 2 No filled in by the Accident Suicide Investigation 6 Could pot be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month,

State Registrar

NGOI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 10:45PM December Medical 2011 4a. Facility Name (if not institution, give street and nu **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) , **Funeral** Hours 6 Director or 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director BALTIMONE 1 ✓ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 9 þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify PHACE Specify: "natural" 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than College (1-4 or 5+) and Mental Hygiene. is marked other tha Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Şurname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If item 27 is any injury or other trainonce. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LAM Signature 22. Name and Address of Facility 23a. Fart 1 Enter the dis shock, of heart failu Immediate Cause (Final her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ Pulmonary disease or condition Medical resulting in death) Examiner months Right Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) attending physician and Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death signed by the at I be detached for g Unknown g X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 🗷 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **X**No 1 Yes မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number MD AT2438946 December 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital 201 E. University Pkwy, Baltimore MD D. Lay 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. dvr 9922 12-28-11 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 08 Month Decemb Tangee R. Mitchell Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Hours Year) **Director** 1 🗆 M 2 🖫 F 215-66-3726 54 Dec.14,1957 MD Usual Residence of Deceden 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director items 23a or 28a-f s ner must be notified MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5475 Moores Run Drive 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or þ 1 ☐ Yes 2★ No If Yes, Give Year or Dates. 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-003 SpecifyBlack Completed 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur iury or other traumatic event, the Medical iury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) vrs Printer Solo Cup Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Douglas Thelma Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Rhonda Mitchell (sister) 2578 Edmondson Ave. Balto, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cem. Dec.31,2011 Baltimore, Md. 21. Signature License CallyIn B. Scruggs Funeral Home Preston St. Balto, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ALL m disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or injury that initiated events and burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months Day Year been signed by the a should be detached f 1 Yes 24 9 Unknown 2. No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by رًا له 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autop., performed autopsy 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to me Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 59540 December 24,201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 00 10 e -0 Good Samaritan Hospital Baltimore, MD. 31. Date filed (Month, Pay, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan		ment of Health and	Mental H	lygiene	0011	11100	
		_	* Registrar	-atl	Certii	icate of Death	2. Date of	Reg. No.	2011	3. Time of Death	
34	Physici /Medic		1. Decedent's Name (First, Middle, La	No NOH			Month	nber	25201	1 8A M	
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	Funeral Director		5. Social Security Number 6. 220 - 89-2522	$\frac{\text{CUMM}}{\text{Sex}}$ 7. Age (In yrs. 1) $\frac{1}{2}$ $\frac{1}{4}$ F $\frac{1}{4}$ $\frac{1}{4}$	last birthday)	Under 1 Year If Under 24 Hours Mi	n. (Month,	Birth Day, Year)	9. Birt	inplace (State or Foreign punity)	
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Locat	on				10d. Inside City Limits	
	Ba-1 eh	Director	MD Hon	JARD Z		TT City				1 ☐ Yes 2 W No	
	3e or 2	i Dire	8587 A	turn Ha	rvest	101. Zip Code 2104	3	10g. Citi	KOR	ountry?	
36	be fited within 72 hours after death with the Maryland nat Hygiene.  ed other than "netural", or Items 23e or 28e-f ehow event, Ira Medical Francer must be mulfied at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	S. 13. Was	S Decedent of Hispanic Origin? as, specify Cuban, Mexican, Put Yes 2 No Specify:	(Specify Yes or erto Rican, etc.)	No-	14. Race - Ame Black, Whit		
215-0036	ithin 72 hour le. len "netural lendical Ex	Completed t	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	(Give kin	i's Usual Occupation d of work done during most of w NOT use retired)	vorking		ond of Business		
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/lan	should be nd Mental marked o	To Be	Ju YONG	NOH		Jin	1 Mo	on	ANH		
e, Maryland	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship	IN (SON)	294	ddress (Street and Number or		Ellic	OTTCI	4, MD 21042	
Baltimore,	Pages 1 nent of H int: If ite iry or otl		20a. Method of Osposition  1 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci	Removal from State		on (Name of or or other place)  IEN LEM 12-	79-7511	100	cation - City or		
altir	permit. Pages Depa tment of Important: If it any injury or c		21. Signature of Futural Service Lice			ame and Address of Facility					
	#Q E # 9		23a. Pert1. Enter the disease, or con	HUON 1	3 10	220 Guilford	Road	Jes	SUP, M	D 20794	
	Physician		shock, or heart failure. List only Immediate Cause (Final	a. Gastroint				y arrest,		Interval Between Onset and Death	
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence)	uence of):		1			A many	
- 4	·	her	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence		Pain				U TIPITAS	
	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. GAS+ 7 C Due to (or as a consequence)	u/ce	r				6 months	
760,	an co	cal E		a Indigest	,					6 months	
x 68	leath certificat attending phy I for use as the	Medi	IF FEMALE:	000 16.000 004.000							
O. Box	The law requires that the death certifica te has been signed by the attending ph vage 2 should be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of di 9 Unknown	Ideath 3□Ec	topic pregnancy her (specify)		-	23d. Date of de Month	livery Day Year	
<b>a</b> .	w requires that the d been signed by the should be detached								d tobacco use contribute to the cause of death		
al Records,	(0)	Completed						utopsy erformed?	prior to death?	utopsy findings available completion of cause of s 2 No	
Vita	s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital:	ER/Outpatient	Other	eath (Check on Home 5 R		6 □Other (Sp.	aciful	
Division of	ding P	-	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?  M 1 Yes 2 No	28d. Descri			nuiy)	
DIVIS	To the Hospital or Attending Physician: whith 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not to determined		ome, farm, street,	factory, office		n (Street an Town, State		ural Route Number,	
	Hospit 24 hour Funere tely fills	Medical (	29a. Certifier 1 Certifying P (Check only one)	hysicien: To the best of my kno miner: On the bass of examina	wledge, death or tion and/or inves	curred at the time, date and pla igation, in my opinion, death of	ice, and due to t curred at the tin	the cause(s) ne, date and	and manner a d place, and du	s stated. e to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	· _ · · · · · · · · · · · · · · · · · ·	29c. License number		29d. Da	te signed (Mon	th, Day, Year)	
	1		1 Kin	m. #	_ , MD	D5247	9	Dec	cember	-, 27, 2011	
	.30m		30. Name and address of person who 3355 Rogers	s Avenue	Ellico	T City, 1	1M 2/0	043			
	Sta Registr		31. Date filed (Month; Day, Year)	32. Pajstrar's Signa	A Low	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ISDOK ARK DEC 2011 00:40 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town or Location of Death 4c. County of Death 06 0 m014 5. Social Security Number unk. 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min Director 1 □ M 2 🗙 F 7-1-1960 51 28a-f show 10a. State 10c. City, Town or Location items 23a or 28a-f shover must be notified at 10d. Inside City Limits Director 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3102 Wh KOREH Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 9 þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry UNK (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filled within 7. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmait. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ 0 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheard failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hemorphag Shock disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami NU The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical Chroni Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a d be detached t g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autonsy 2 🗌 No Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1/ Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this (filled in by the funeral di 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1- Natural iniury work?
1 Yes 2 No 5 Pending Accident Suicide Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 70598 Dec 26, 2018 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) 5755 CEDAR LANE, COLUMBIA MD 21044

State Registrar

31. Date filed (Mo

KHTAR

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month YE ANG JUNUS Decombe 20/1 Medical Facility Name (if not institution, give street or Location of Death 4c.,County of Death **Examiner** 4b. City, Town Columbis Howard towara Coun Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreig Country) **Funeral** 265-55-9087 **Director** 1 🗆 M 2 🕱 F 78 10-09-1933 Korea 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Ellicott City 1 🗌 Yes 2 🏻 No MD Howard 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be Funeral United States 21043 3000 N. Ridge Lane items . Page 1 and 2 should be filed within 72 hours after death viment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural", or items luny or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify. Completed 3 Widowed 4 Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jum Bae Ki S. Peang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2925 St. John's Lane, Ellicott City, MD 21042 Kenneth D. Peang - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12-24-2011 Glen Burnie, MD of Juneral Service Lidensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory entest, shock, or heart failure. List only one cause in each line Approximate Interval Between Onset and Death Immediate Cause (Final Pittysician/ HCU disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a cons Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical ul or Attending Physicians: The law requires that the death certificate be eafter death.

Director: After this certificate has been signed by the attending physicia P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 for Pregnant at time of death Unknown signed by the at Id be detached for Yes 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2. No Other ပ္ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ 29b. Signature and title of certifie 29c, License number **306 4** F of death (Item 23a) (Type, Print)

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Registrar

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State

31. Date filed (Mont

Back RIVER NECK Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:09 PM Poole Keginald 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical University Baltimore 6. Sex 7. Age (In yrs, last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-64-8341 Hours (Month, Day, Year) **Director** 1 NM 2 F 57 2-22-95 Mary land Usual Residence of Deceder 10a. State 10d. Inside City Limits 10b. Count 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 Les 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2501 21215 ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Black Specify: "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) aborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Mejden Surname 2 00/2 C-19a. Inform t's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) Neal dalle 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Name and Address arthy 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ henorrhage Intracerebral disease or condition resulting in death) days Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Day 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HERRYITIS Were autopsy findings available prior to completion of cause of death? 24a, Was an Director: After this certificate has autonsy 1 Yes 2 No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined 24 hours a Medical 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 29b. Signature and title of certified 29d. Date signed (Month. Day, Year 1669764692 12/18/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Greene St Baltmore, MD South 21201 Suite 12D Year)

State

Registrar

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#21perFam, G922, 12/28/2011, WS
State of Maryland / Department of Health and Mental Hygiene 50U Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death tchard Month Physician Day 36 Charles 8-M 33 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c County of Death Examiner Bosto mo arrows for a 2918 POINT Sparrows Rd. If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days **X** M 2□ F Months Hours Min 89 74-30 3 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Evaluation must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Sparrows 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event. 2918 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crane Mill 12 STecl Industr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be citchara Made ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21219 19a. Informant's Name/Relationship (Type, Print) Patricia Pritchard Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 2918 Point POINT, MD Sparrous 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 15425 4 Donation 5 Dother (Specify) Rita's Cemetery ST. 12/24/2011 Connellsville PiA 21. Signature of Fungral Service see Matthew Pritchard 22. Name and Address of Facility 21219 2918 POINT, MD sparrows Point Rd., Sparrows 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1800 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day signed by the a d be detached fo 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has I in by the funeral director, page 2 s 2 No 1 □Yes 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Statement 6 Other (Specify) Hospital: 2 No 1 Tes ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Iniury within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 WILL ( 32. Registrar's Signature State Registrar